

# Statewide Call for Action: A Strategic Plan for a Children's Mental Health Redesign in Iowa

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by

**The Coalition for a Children's Mental Health Redesign in Iowa:**

A grassroots, parent-led, coalition: we are organizations and individuals working together to find solutions to Iowa's current children's mental health crisis.

Suicide is the second leading cause of death among persons aged 10 – 24.<sup>1</sup>

The suicide rate for African American children *has doubled* since the 1990's.<sup>2</sup>

90% of those who die by suicide experience mental illness.<sup>3</sup>

Over 20% of children have a seriously debilitating mental illness during their lifetime.  
(Over 45% of children have had any mental illness.)<sup>4</sup>

Half of all lifelong cases of mental illness begin by age 14 (75% by age 24).<sup>5</sup>

80% of children who need mental health treatment *never receive treatment*.<sup>6</sup>

Minority children are half as likely to receive *any* mental health services<sup>7</sup> and more likely to receive services that are inappropriate, fragmented, or inadequate.<sup>8</sup>

70% of youth in state and local juvenile justice systems have mental illness.<sup>9</sup>

50% of youth in the child welfare system have mental illness.<sup>10</sup>

Treatment works. Treatment of mental illness reduces disability, leads to recovery and is *most effective* during the brain's development from *birth to age 26*.<sup>11</sup>

**Without a *systematic approach* and *point of accountability*:**

*Our children will continue to die.*

## Executive Summary

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### **Iowa's children are dying.**

- 90% of those who die by suicide experience mental illness.<sup>12</sup>
- According to the Iowa Youth Survey (2012)<sup>13</sup>:
  - 13% of Iowa's youth in grades 6, 8, and 11 (or 13,772) reported having seriously thought about killing themselves within the past twelve months
  - 7% (or 7,415) of these young people reported having an actual suicide plan.
  - Youth suicide is more prevalent in Iowa than in the nation as a whole.
- There are 64,000 children in Iowa with substantial functional impairment caused by mental illness who do not receive *any* mental health services.<sup>14</sup>

### **Iowa's children are dropping out of school and being incarcerated.**

- Approximately 50% of students with mental illness drop out of school. "Once they leave school, these students lack the social skills necessary to be successfully employed; they consequently suffer from low employment levels and poor work histories."<sup>15</sup>
  - 70% of youth in state and local juvenile justice systems have mental illness. Yet, the U.S. Department of Justice has found that juvenile facilities fail to provide adequate mental health care.<sup>16</sup>

### **Iowa is paying a fortune for not paying attention.**

- The price tag to the state of Iowa to incarcerate youth with mental illness exceeds \$9.4 million annually. Providing wraparound services through system of care programs for the same number of youth and their families would cost an estimated \$229 thousand annually, a return on investment of up to \$40.31 for every dollar invested in wraparound care.<sup>17</sup>
- Further, wraparound would save \$2.75 in medical costs for every \$1 invested.<sup>18</sup>
- These figures do not include the enormous financial impact from school drop out, homelessness, unemployment or lost tax revenue.

**No numbers can quantify the human loss of life, grief of families,  
or the collective loss of potential.**

*The good news is that treatment works, but only if a child can access it.*

### **This is a call to action to:**

- 1) Stop the criminalization of mental illness.
- 2) Build a statewide children's mental health system that includes an array of effective services.
- 3) Be in full compliance with and enforce federal mandates.

**Investing in system of care programs across the state not only makes fiscal sense,  
it is the right choice for children and families.**

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## Introduction

This is a call to everyone on behalf children. Fixing this crisis will require joint effort by elected officials; community leaders; government agencies and private organizations at the state, regional, county and local levels. It will require that Iowans let their elected officials know children's mental health matters. It will require that advocates speak together in a unified voice.

*Please note that this is a work in progress and will continue to be updated.  
Input from all stakeholders is welcome.*

The following recommendations are meant to be a guide for the implementation of a holistic system that integrates strategies for improving the health, education, safety, and social wellness of children with mental health needs. These recommendations take the form of:

**Strategic Objectives** - long-term objectives to be accomplished in 2-5 years

**Operational Objectives** - specific outcomes to be accomplished to ensure strategic objectives are met

**Action Items** - specific steps to accomplish operational objectives

We are encouraged by the approval of the Children's Mental Health Workgroup,<sup>19</sup> a study group of stakeholders facilitated by the Department of Human Resources in cooperation with Departments of Education and Public health. Our coalition is very happy to have representation on the Workgroup, which will provide a recommendation for building a children's mental health system to the legislature and Governor on December 15, 2015. These meetings are open to the public and we welcome input to bring to the meetings (send to [namiowacmhc@mediacombb.net](mailto:namiowacmhc@mediacombb.net)). There is one remaining meeting on December 3 from 10-3 pm at the State Capital Building. Contact us at the above address for the room number.

We will update this document with progress made at the state level and encourage individuals and organizations to work on these issues at their local organizations, cities, and counties. If you are interested in coordinating efforts, please contact [namiowacmhc@mediacombb.net](mailto:namiowacmhc@mediacombb.net). Please keep us informed of your efforts so we can share them here.

*Together we can save the lives and futures of our state's most precious resource:  
Its children.*

# The Coalition Membership

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We are the Coalition for a Children's Mental Health Redesign, a group of individuals and organizations with expertise and lived experience in children's mental health, education, safety, development and wellbeing. Our work is parent driven through the NAMI Iowa Children's Mental Health Committee in partnership with the Iowa Mental Health Planning and Advisory Council.

## Coalition Leadership

### Co-chairs of Coalition:

Tammy Nyden and Renee Speh, Co-chairs of the NAMI Iowa Children's Mental Health Committee 2014-2015

[namiowacmhc@mediacombb.net](mailto:namiowacmhc@mediacombb.net) and [reneespeh@gmail.com](mailto:reneespeh@gmail.com)

**Chair of Education Sub-committee:** Ellen McGinnis-Smith: [ELMcSmith@aol.com](mailto:ELMcSmith@aol.com)

**Chair of Health Sub-committee:** Kathy Leggett, [Kathy.Leggett@unitypoint.org](mailto:Kathy.Leggett@unitypoint.org)

### Coordinating chair of Implementation beginning September 2015:

Teresa Bomhoff, Chair of the Iowa Mental Health and Planning Council

[tbomhoff@mchsi.com](mailto:tbomhoff@mchsi.com)

## Core Committee Members

Beall, Daryl  
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Leggett, Kathy  
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## Member Organizations

American Academy of Pediatrics (AAP) Iowa Chapter	Iowa Foster & Adoptive Parents Association (IFAPA)
Autism Society of Iowa	Iowa Juvenile Justice Advisory Council
Blank Children's Hospital	Iowa Mental Health Planning and Advisory Council
Boys and Girls Home and Family Services, Inc.	Iowa Nurses Association (INA)
Brain Injury Alliance of Iowa	Iowa Prevention of Disabilities Policy Council
Center for Disabilities and Development at University of Iowa Children's Hospital	Iowa Psychiatric Society (IPS)
Central Iowa ACES 360	Iowa School Nurse Association (ISNA)
Children's Center for Therapy	Lutheran Services in Iowa
Children's Square USA	Mid-Iowa Health Foundation
Coalition for Family and Children's Services in Iowa	NAMI Greater Des Moines
Disability Rights Iowa	NAMI Iowa
Epilepsy Foundation North / Central Illinois, Iowa & Nebraska	National Association of Social Workers Iowa Chapter
Family Resources, Inc.	Parents Creating Change in Iowa
Family Services	Please Pass the Love
Four Oaks	Prevention and Disability Council
Governor's Autism Council	Quakerdale
If You Really Knew Me, club at City High, Iowa City	Tanager Place
Iowa Association for Infant and Early Childhood Mental Health	The Arc of Southeast Iowa
Iowa Association of Nurse Practitioners	The Iowa Association for Infant and Early Childhood Mental Health
Iowa Behavioral Health Association	University of Iowa Children's Hospital Autism Center
Iowa Counseling Association	United Way of Central Iowa
Iowa Developmental Disabilities Council	Woodward Community Based Services
Iowa Family Services	Young House Family Services
Iowa Federation of Families for Children's Mental Health	Youth and Shelter Services, Inc. (YSS)

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# History

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## 2011

In 2011, Senate File 525 established a plan to redesign Iowa's mental health and disability services. The plan called for "...the development of services that implement the principles of Olmstead<sup>20</sup> so that Iowans with disabilities, no matter where they reside, can live safe, healthy, successful, productive, self-determined lives in their homes and communities."<sup>21</sup> To this end, six Redesign Workgroups were formed:

1. Intellectual Disabilities and Developmental Disabilities,
2. Adult Mental Health,
3. Children's Disability Services,
4. Regionalization,
5. Judicial – DHS,
6. Services for people with Brain Injury and
7. Psychiatric Medical Institutions for Children.<sup>22</sup>

Of the 7 workgroups, SF525 established a two-year timeframe for the Children's Disability Services Workgroup (CDSW) (2011-2012).

In 2011 members of the Children's Disability Workgroup voiced the following concerns:

"I'm concerned that to have a truly good system of care we will need multiple funding sources that are new and not tied to core standards. The Legislature is tied to having core standards and it might not work for kids as it does in an adult system of care. We are not about just having specific services in order to bring the kids back home."

"The real key is the funding for the System of Care, and how it will meet the needs of the children and families. The funding has to be a primary focus."

***"We are charged to design something that does not really exist.*** We are a little different than the other workgroups. I want to be clear that we have to develop an infrastructure and have the funding to build the infrastructure for coordination and quality to achieve the outcomes we want. The funding is often available at the end but we have to build the components and the infrastructure to that end."

"This is as thorough a process as it could be in a short period of time. ***But, there are not enough families around the table.***"<sup>23</sup>

## 2012

Their 2012 Final Report recommended that Iowa:

“Create, through legislation, a state level Iowa Children’s “Cabinet” that will provide guidance, oversight, problem solving, long-term strategic thinking, and collaboration led by Department of Human Services and includes representatives of child serving agencies and local systems as they create specialized health homes and build out from serving a discrete population to a comprehensive, coordinated system for all children.”

Further they recommended a governance structure for the first phase of implementation that “*...includes family representation, community representation and representation all of the state level agencies that serve children and families...*”

The recommendations were not followed; however Senate File 452 authorized a one-year extension of the workgroup to continue “its work in developing a ‘proposal for publicly funded children’s disability services for children and families that ensures children with mental health needs and intellectual disabilities receive the services they need.’”<sup>24</sup>

## 2013

Their November 13, 2013 Final Report made the five following recommendations:

1. Establish the Iowa Children’s Interagency Coordinating Council
2. Establish the Iowa Children’s Advisory Council
3. Consolidate or eliminate redundant, duplicative, or conflicting children’s committees.
4. Establish a minimum set of core services that should be available to all children.
5. Convene an assessment task force to make recommendations about adoption of standardized function assessment tool(s).

Their report stressed:

“...that a formal governance structure is necessary to ensure that there is coordinated, deliberate attention to the mental health and disability service needs of Iowa’s youth who touch the public system. While the Workgroup acknowledged that the focus of this year’s effort was limited to the mental health needs of youth, the Workgroup strongly advises that all planning efforts meet the multi-dimensional needs of youth and their families moving forward.”<sup>25</sup>

Further, in an effort to “minimize potential for duplication” they also recommended:

...that this committee, the Children’s Disability Services Workgroup, be **disbanded**. All future work involving the planning, design and implementation of Iowa’s children’s system of care should flow through and be coordinated with the work of

the Interagency Coordinating Council and the Children's Advisory Council identified in recommendations one and two.<sup>26</sup>

The workgroup did disband, however ***none of the five main recommendations were followed*** and so there was no Interagency Coordinating Council or Children's Advisory Council to continue this important work. The only recommendation from this workgroup that became part of Iowa's Redesign of Mental Health and Disability Services was the creation of specialized Health Homes to provide family peer support.<sup>27</sup> However, as of September 2015, most of the health homes only provide family navigators, ***not additional services***.

Children were not part of the Mental Health Redesign's regionalization - ***it became an adult system redesign only*** - and with the disbanding of the Children's Disability Workgroup, ***Iowa's children were left behind***.

### **2015: Where we are now**

The Coalition for a Children's Mental Health Redesign in Iowa came about in an attempt to move forward from talk to implementation. The coalition has benefited from the experiences of its members as parents, caregivers, providers, mental health professionals, advocates and consumers.

We are encouraged with the approval of the Children's Health and Well-Being Workgroup (as part of Senate File 505 in 2015) and look forward to having Coalition representation in that workgroup. We thank those who were involved in previous efforts and want to acknowledge that we are building on their good work.

We appreciate that creating an infrastructure that currently does not exist is not an easy task and will require time, funding, and commitment. We believe the most effective approach is holistic systems change at the state level, something that other states are doing with success.<sup>28</sup> That said, we appreciate the importance of positive incremental change.

This strategic plan offers general recommendations for holistic systems change as well as particular goals and action items that can accommodate both holistic and incremental approaches. The plan addresses needs in four interrelated areas: health, education, safety, and social-wellness. These recommendations are ready to be put in action.

# Mission, Vision, Core Values and Guiding Principles

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## Mission

Through positive systems change, Iowa will implement a nationally recognized, inclusive model of excellence in health care, education, safety and the social wellbeing of children with mental health needs.

## Vision

The public and all individuals working with or on the behalf of children will have a general understanding of children's mental health and an appreciation for neurodiversity.

## Core Values

### Rights of the Child

**Culturally Competent and Responsive Care**

**Human rights protection and advocacy**

**Nondiscrimination in access to services**

**Prevention of physical and mental illness and trauma**

**Early identification and intervention**

**Family and consumer participation in all aspects of planning, service delivery and evaluation**

**Iowa has a legal and moral obligation to uphold the rights outlined in:**

**UNICEF's Rights of the Child<sup>29</sup>**

**Olmstead Act<sup>30</sup>**

**Individuals with Disabilities Education Act 2004<sup>31</sup>**

**(Including Free and Appropriate Public Education and the Child Find Program.)**

## Core Values

### **Mental Health is a Key Part of Overall Health and Wellbeing**

#### ***Services must serve the whole child***

- Mental health, education, safety, and social wellness are of fundamental importance in the development of each and every child.
- Mental illness has emotional, cognitive, physiological, and social symptoms.
- Many psychotropic medications have physical side effects.
- Children suffering from critical or chronic physical illness often experience depression, anxiety, and / or isolation.
- Many children have co-morbid conditions crossing over traditional categories of services and funding streams (Serious Emotional Disturbance, Intellectual Disability, Physical Disability, Brain Injury, etc.)

#### ***Services must be tailored to the needs of the particular child.***

- Similar behaviors can have different causes requiring different approaches.<sup>32</sup>
- To be effective and humane, strategies to modify behavior must take into account the underlying cause (e.g., neurological conditions, brain injury, emotional trauma, learning disabilities, etc.).

#### ***Services must support the whole family***

- A child's mental illness affects the mental health, relationships, finances, and wellbeing of each member of the family.
- Studies have shown that the stress of caring for a child with mental illness decreases one's life expectancy, causes chronic physical illness, and has the same emotional and physiological results as the combat stress.

## Guiding Principles

### Systems of Care

**Individualized service planning to meet the needs of the child and family**

**Team coordinated and family driven Wrap-Around Care**

**Integrated services with coordinated planning across all child-serving systems**

**Smooth transition to adult service program**

**Services must be flexible to meet child's current needs, noting that symptoms can cycle, ebb and flow, or change as child ages.**

**Services should be empirically supported.**

## Guiding Principles

### Full Continuum of Services

Infrastructure for new services or programs must be built and immediately ready for implementation *before* removing any needed existing services or programs.

Services must be timely and accessible. (Brains undergo significant development until the age of 26. Services delayed are services denied and result is increased disability.)

No child should be institutionalized due to a lack of community services.

No child a danger to oneself or others should be denied care because of the lack of availability of beds or services.

# I. Build array of effective services.

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## **Strategic Objective A: Build a statewide children's mental health system that includes an array of effective services.**

Iowa will create, support and sustain an excellent Children's Mental Health system embodying the Core Values and Guiding Principles outlined in this document by the year 2020. This system will serve those living in Iowa, ages birth to 26 years old.

### **Operational Objective A.1: Interagency cooperation for effective use of resources**

State agencies will work together for the most effectively use of state resources to address children's mental health needs.

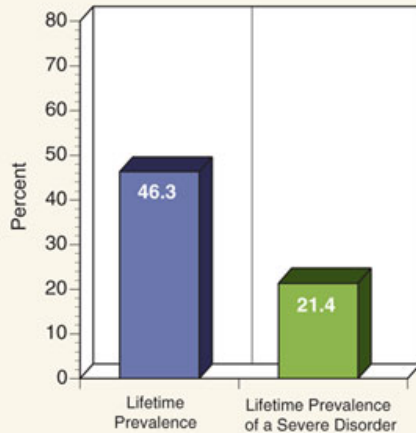
### **Children's mental illness is a systemic problem in need of a systematic solution**

- Almost one-half of children age 10 to 17 in the United States have experienced one or more ACE (Adverse Childhood Experiences).<sup>33</sup>
- At least 20% have symptoms so severe that their ability to function is significantly impaired.<sup>34</sup>
- Half of youth in the child welfare system have mental health problems.<sup>35</sup>
- 70% of youth in state and local juvenile justice systems have mental disorders. Yet, the U.S. Department of Justice has found that juvenile facilities fail to provide adequate mental health care.<sup>36</sup>
- The average delay of onset of symptoms to treatment is 8-10<sup>37</sup> years, throwing away our chance to intervene during critical years in brain development to prevent severe disability, criminality, and further trauma.<sup>38</sup>

## Any Disorder

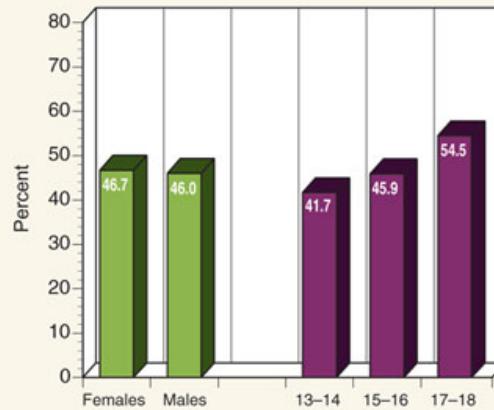
### Lifetime Prevalence of 13 to 18 year olds

- **Lifetime Prevalence:** 46.3% of 13 to 18 year olds
- **Lifetime Prevalence of "Severe" Disorder:** 21.4% of 13 to 18 year olds have a "severe" disorder



### Demographics (for lifetime prevalence)

- **Sex:** Not statistically different
- **Age:** Statistically different



- **Race:** Statistically significant differences were found between non-Hispanic whites and other races

Merikangas KR, He J, Burstein M, Swanson SA, Avenevoli S, Cui L, Benjet C, Georgiades K, Swendsen J. Lifetime prevalence of mental disorders in U.S. adolescents: Results from the National Comorbidity Study-Adolescent Supplement (NCS-A). *J Am Acad Child Adolesc Psychiatry*. 2010 Oct;49(10):980-989.

Source: <http://www.nimh.nih.gov/health/statistics/prevalence/any-disorder-among-children.shtml>



- Action Item A.1.1:** Develop common language and outcomes for interagency use regarding children's mental health and wellbeing.
- Action Item A.1.2:** Develop a set of outcome measures (direct and indirect) to assess the state of children's behavioral and emotional health in Iowa.
- Action Item A.1.3:** Monitor and report on agreed upon outcome measures reflecting the behavioral and emotional health of children in the state (a report card).
- Action Item A.1.4:** Make accessible and transparent public report of the overall progress of the state in achieving the desired children's behavioral health outcomes.
- Action Item A.1.5:** Create a three-year pilot central interagency coordinating council to serve as an umbrella structure:
- a. That supports joint decision making and trends toward joint funding for children's mental health services
  - b. that takes input from:
    - The family advisory councils of every Managed Care Organization (MCO) under contract of the state
    - The relevant state advisory councils (e.g., The Iowa Mental Health Planning and Advisory Council).
  - b. that identifies:
    - measures needed to effectively evaluate the mental health and wellbeing of Iowa's children and the effectiveness of current services and policies across departments (including arrest and incarceration rates, school drop out, drug use, etc.)
    - gaps in current array of services
    - interagency priorities to improve array of services
    - strategies for interagency cooperation to fund and provide needed services
    - funding to set up a statewide children's mental health system (including Federal and private grants)
  - c. that aligns rules across MCO's
  - d. that reports twice a year to the Governor and Legislator
    - the current status of children's mental health care in Iowa
    - annual priorities for funding, policy and legislation needed to evaluate and improve upon the array of children's mental health services throughout the state
  - d. The coordinating council will consist of:
    - An elected official who will serve as chair and a point of accountability (e.g., Lt. Governor)
    - A senior representative from:
      1. The Department of Human Services
      2. The Department of Education

3. The Department of Public Health
  4. The Department of Corrections
  5. The Department of Human Rights (Division of Criminal and Juvenile Justice planning)
  6. The Civil Rights Commission
- Family members with lived experience of caring for child with Serious Emotional Disturbance (no less than 51% of the council)
  - Other stakeholders

**Action Item A.1.6: Pass legislation to implement an ongoing interagency coordinating structure as described in A.1.5 or as recommended by the pilot council.**

#### **Operational Objective A.2: Wraparound services**

Iowa will establish a structure that serves as a center for hiring, training, and oversight of child-focused teams that provide and coordinate services that are child and family focused, community based, culturally competent, and flexible. Every child in Iowa with serious mental illness will immediately be assigned a team upon diagnosis and will receive these services in their community, regardless of location and healthcare coverage.

Currently the only children with serious mental illness that are placed in a Pediatric Integrated Health Home are those who qualify for Medicaid. ***Very few*** of these health homes ***provide services*** beyond assistance to families in navigating the disparate array of children's mental health services that already existed (before the Mental Health Redesign). While family navigation tools are important, ***they are meaningless for the multitude of Iowa families who have no accessible services.*** Only those on the Medicaid Children's Mental Health Waiver get additional services, but the waiting list is almost 3 years long and the number of waiver slots can only accommodate a fraction of those in need. All children with serious mental illness need team that provides wraparound services regardless of location or healthcare status.

### Wraparound Services<sup>39</sup>

Wraparound services are individualized community-based services that focus on the strengths and needs of the child and family. Wraparound services are developed through a team-planning process, where a team of individuals who are relevant to the well-being of the child (such as family members, service providers, teachers, and representatives from any involved agency) collaboratively develop and implement an individualized plan of care, known as a wraparound plan.

The services in a wraparound plan are designed to meet the goals set by the child and family team and to provide flexible support to the child and family. The services in a wraparound plan, also known as direct support services, differ from traditional mental health services because they:

- Are primarily provided in the homes of families and in settings in the community rather than in an office setting;
- Are available when families need them, including after-school, in the evenings or on the weekends instead of only during office hours;
- Emphasize treatment through participation in purposeful activities, giving children the opportunity to practice life skills and make positive choices through involvement in community activities, instead of focusing on treatment through talking about problems; and
- Are built around engaging the child and family in activities that interest them and meet their goals instead of just around a goal of stopping negative behaviors.

Wraparound services are generally considered among the most effective interventions for children with emotional, behavioral and mental health needs and are essential to any children's mental health system. Studies have found that these children make substantial improvements when provided wraparound services instead of institutional care, including that they:

- Are hospitalized less often;
- Have fewer arrests and stays in detention;
- Sustain their mental health improvements;
- Have less suicidal behavior; and
- Have better school attendance and achievement.

The Surgeon General has embraced the effectiveness of community-based services like wraparound services, both in the Surgeon General's **Report on Mental Health** and the **Report on Youth Violence**. Moreover, wraparound services not only have better outcomes but also cost far less than more restrictive institutional and group care.

Surgeon General's **Report on Mental Health** and the **Report on Youth Violence**:

<http://www.ncbi.nlm.nih.gov/books/NBK44295/>  
<http://profiles.nlm.nih.gov/ps/access/NNBBHS.ocr>

The state of Oregon has adopted the wraparound approach:

<http://www.oregon.gov/oha/amh/wraparound/docs/child-adolescent-mh-wraparound.pdf>

- Action item A.2.1:** Identify and create responsible governmental entities for infrastructure development and oversight, including funding, training, network development of systems of care that ensure, provide, and coordinate services for the individual child.
- Action Item A.2.2:** Build on current Pediatric Integrated Health Homes infrastructure by adding *services and resources* to meet the standards of Systems of Care / Wraparound services.
- Action Item A.2.3:** Collaborate with existing initiatives (including the effort to create a statewide strategic plan for the Regional Autism Assistance Program<sup>40</sup> led by the University of Iowa).

**Operational Objective: A.3 A Core Set of Services**

A core set of mental health services will be available and accessible to every child in Iowa with serious mental illness regardless of location or health coverage by the year 2020.

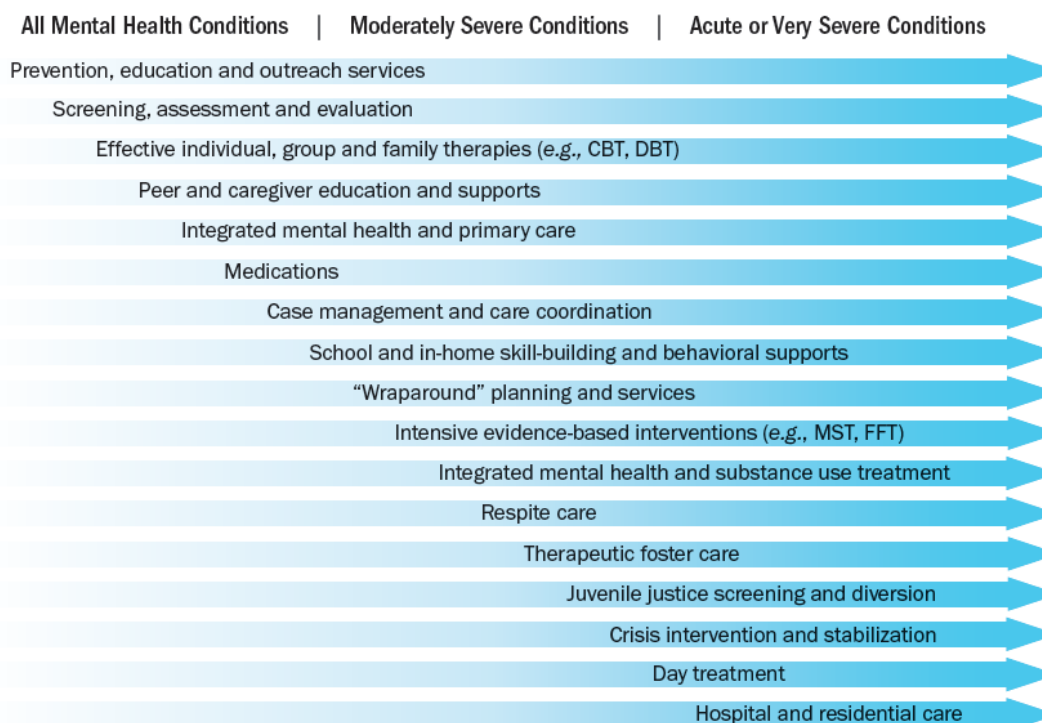
- Action Item A.3.1:** Develop a list of core services in each of the following domains that must be available to any child (age birth to 26) with serious mental illness in order to fully meet the standards of federal and state mandates.
- Prevention
  - Early Identification and Intervention
  - Behavioral and Emotional Health Treatment
  - Recovery Supports
  - Community Based Flexible Supports
- Action item A.3.2:** Expand telemedicine to provide therapies and other core services to far-reaching and rural areas<sup>41</sup>
- Action Item A.3.3:** Determine current barriers to immediate access of each of these core services.
- Action Item A.3.4:** Report these barriers to the legislator and governor's office with suggested legislation to remove barriers.

**Operational Objective A.4: Full continuum of care**

The full continuum of children's mental health care will be available and accessible; i.e., Iowa will have the mental health workforce and dedicated resources to ensure the availability and accessibility of the full continuum of care.)



## Child and Youth Mental Health Service and Support Array



- Action Item A.4.1:** Determine, report, and make available to the public the current use and unmet need of pediatric psychiatric hospital beds, PMIC beds and beds in all other long-term placements for behavioral or emotional health needs. This report should include any requirements to access particular services (e.g., must the child be a ward of the state, i.e., a Child in Need of Assistance (CINA) to access a group home.)
- Action Item A.4.2:** Use the new bed-tracking system to collect data on how long children are waiting in emergency rooms for inpatient pediatric psychiatric beds to open or being turned away because of lack of beds. This data will track location, frequency, and time to admission.
- Action Item A.4.3:** Use collected data to determine actual need (by location) of pediatric psychiatric hospital beds, PMIC beds and beds in all other long-term placements for behavioral or emotional health needs.
- Action Item A.4.4:** Fund creation of additional beds in areas of need.
- Action Item A.4.5:** Continue and expand funding for recruitment and training of children's mental health specialists at all levels.
- Action Item A.4.6:** Ensure adequate and equitable reimbursement for telepsychiatric services paid for by Medicaid and private insurance
- Action Item A.4.7:** Maintain integrity and continue funding for the rural health physician loan forgiveness program to encourage psychiatrists to serve in rural areas

## **Strategic Objective B: Standardized Training**

All persons working with or on behalf of children will have the children's mental health training needed to identify, support and / or refer children in need of mental health services.

### **Operative Objective B.1: First-contact health care providers**

Iowa will have a standardized training program for first-contact healthcare providers about children's mental health and trauma informed care. First-contact health providers include (but are not limited to) family physicians, pediatricians, internists, physician assistants, nurse practitioners, school nurses, and paramedics.

- Action Item B.1.1:** Create and / or approve standardized children’s mental health curriculums appropriate for each level of first-contact healthcare.
- Action Item B.1.2:** Partner with Iowa institutions of higher education and professional organizations to provide this training and certification.
- Action Item B.1.3:** Mandate standardized training.
- Action Item B.1.4:** Set up telemedicine program to provide trainings and a means for first-contact health providers to consult with mental health specialists.

#### **Operative Objective B.2: School staff**

Iowa will have standardized training for all public school staff and Area Education Agency (AEA) staff who work with or make decisions on behalf of children.

- Action Item B.2.1:** Create and / or approve standardized children’s mental health curriculums appropriate for each category of school staff (e.g., administration, classroom staff, counselors, coaches, etc.).
- Action Item B.2.2:** Build private and public partnerships to obtain training for school staff and services youth, particularly in rural settings.
- Action Item B.2.3:** Mandate standardized training.
- Action Item B.2.4:** Set up telemedicine program to provide trainings and a means for school personnel working with child to consult with mental health specialists and other members of the students’ SOC / Wraparound team.

#### **Operational Objective B.3: DHS, Group Homes and Foster Care System**

All staff working with or making decisions on behalf children at DHS, group homes, and the foster care system will have training in children’s mental health, ACEs, cultural competency and support for families.

- Action Item B.3.1:** Determine standardized training and certification for all working with or on behalf of children in DHS, group homes, and the foster care system, including foster parents and anyone having visitation with the child.
- Action Item B.3.2:** Fund training and certification for all working with or on behalf of children in DHS, group homes, and the foster care system, including foster parents and anyone having visitation with the child.
- Action Item B.3.3:** Mandate training and certification for all working with or on behalf of children in DHS, group homes, and the foster care system, including foster parents and anyone having visitation with the child.
- Action Item B.3.4:** Provide ongoing training on children's mental health, ACEs and cultural competency and support for families adopting child from Foster Care system.

### **Strategic Objective C: School Based Mental Health Supports**

Public schools will be an integral member of the children's mental health system<sup>42</sup>

**Because children cannot learn when they are not well:**

*"Mental health disorders were found to be significantly associated with termination of schooling prior to completion of each of four educational milestones (primary school graduation, high school graduation, college entry, college graduation)...the largest (was) for high school graduation...these results add to a growing body of evidence documenting a wide variety of adverse life course effects of mental disorders."*<sup>43</sup>

**Because school is the only point of access to services for many children**

- *11.5% of adolescents receive mental health services in an education setting, compared to 12.5% in a specialty mental health setting (inpatient or outpatient.)*<sup>44</sup>
- *"Research suggests that schools may function as the de facto mental health system for children and adolescents"*<sup>45</sup>

**Because school-based mental health supports:**

- **Improve academic success** (e.g., grades, standardized test scores, grade point averages, academic motivation, and commitment to school).
- **Decrease problem behaviors** including violence and bullying. <sup>46</sup>



**Schools can address ACEs and resulting trauma through three key strategies:**

1. Integrate strong social emotional learning practices in the academic mission. Educational research demonstrates that high-quality social emotional learning practices are highly predictive of school success. A variety of promising practices and evidence-based programs are available, but require high-quality and persistent implementation if they are to produce meaningful benefits.
2. Increase access to early intervention and treatment resources for the most vulnerable students and families. Understanding trauma from ACEs as an intervention framework for students is essential. There is an opportunity to build well-coordinated education and treatment systems of care employing trauma from ACEs as an essential service.
3. Investigate the potential to more formally use trauma-informed principles in student supports and learning strategies. While this work is early in development, a number of trauma-informed models complement social emotional learning in schools. These strategies may help reduce problem behaviors that compromise the success of schools by shifting resources to discipline and behavior management and away from universal high-quality education.

This passage is quoted from Christopher Blodget, “No School Alone: How Community Risks and Assets Contribute to School and Youth Success.” Report prepared for the Washington State Office of Financial Management in response to the Legislature’s directions in Substitute House Bill 2739, pages 5-9.

[http://www.erdc.wa.gov/briefs/pdf/no\\_school\\_alone.pdf](http://www.erdc.wa.gov/briefs/pdf/no_school_alone.pdf)

**Operation Objective C.1: Multi-tiered system**

Implement a multi-tiered system of mental health supports in all Iowa public schools

### **Multi-level System of Support**

Historically, school reform efforts emphasized collaboration, high-quality instruction, and balanced assessment. RtI [Response to Intervention] provides a systematic approach that integrates these three essential elements within a multi-level system of support to maximize student achievement.

A multi-level system of support is the practice of systematically providing differing levels of intensity of supports (interventions/additional challenges, collaborative structures, monitoring of student progress) based upon student responsiveness to instruction and intervention. Within an RtI system, schools:

- Use data to identify students at risk for poor learning outcomes or in need of increased challenge
- Monitor student progress
- Intervene based on student need
- Adjust the intensity and nature of interventions or challenges depending on a student's responsiveness

Factors, such as effective leadership, universal design for learning, meaningful family and community involvement and data-based decision-making enhance a multi-level system of support.

This passage is quoted from the Wisconsin RtI (Response to Intervention) Center Website:

<http://wisconsinrticenter.org/educators/understanding-rti-a-systems-view/multi-level-system-support.html>

For a guide on how to implement Wisconsin's Multi-Level Systems of Support see: "Wisconsin Guide to Intervention: A Guiding Document" Wisconsin Department of Public Instruction Tony Evers, PhD, State Superintendent Madison, Wisconsin 2010. Available at:

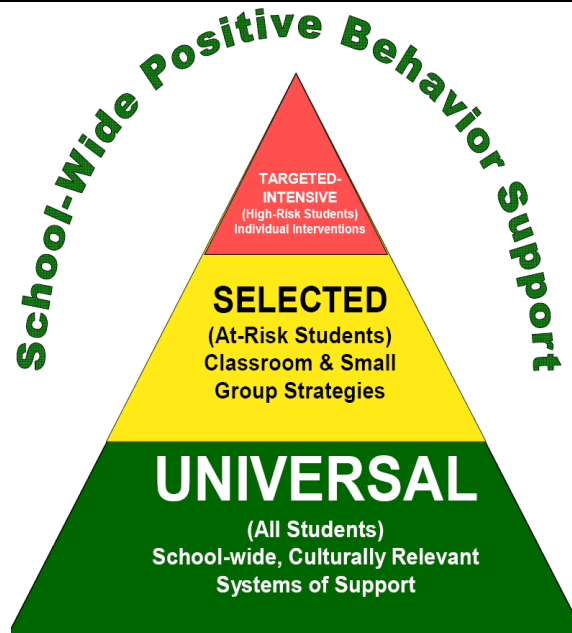
<http://wisconsinrticenter.org/assets/files/rti-guiding-doc.pdf>

**Action Item C.1.1: All Iowa public schools will teach social emotional learning effectively as part of their core academic mission by implementing school-wide programs that promote student wellness, social skills and resiliency including PBIS (Positive Behavior Interventions and Supports) and Restorative Justice.**

### Positive Behavior Intervention and Supports (PBIS)<sup>47</sup>

Positive Behavior Intervention and Supports (PBIS) is a system for improving school climate and preventing and reducing disciplinary incidents. Using PBIS, schools develop school-wide discipline plans that include:

- Developing core values for the school community;
- Training teachers and staff in classroom management and positive behavior support strategies to recognize and reward positive student behavior;
- Using positive interventions when disciplinary issues happen, such as counseling, conflict resolution, mediation, and team interventions;
- Using data to monitor and improve discipline
- policies to meet the needs of teachers and students.



Three Tiered Approach to PBI  
From the Los Angeles Unified School District  
<http://Disciplinepolicy.lausd.net>

### The Data

In Illinois, there are over 600 schools implementing PBIS with positive results, including reduced disciplinary referrals and improved academic outcomes for students:

- At Carpentersville Middle School, after implementing PBIS, office disciplinary referrals fell by 64% from 2005 to 2007. During the same period, the number of students that met or exceeded standards for 8th grade increased by 12.3% in Reading and 44% in Math.<sup>48</sup>
- In 12 Chicago public schools, the number of students who received six or more disciplinary referrals fell by more than 50% over three years after implementing PBIS.<sup>49</sup>

In Florida, a study of 102 schools using PBIS found that after one year of implementation:

- Office disciplinary referrals fell by an average of 25%,
- Out of school suspensions fell by an average of 10%.<sup>50</sup>

The Los Angeles Unified School District passed a district-wide policy in 2007 to implement school-wide positive behavior support in every school in the district.

- During the first 2 years of implementation, overall suspensions dropped by 20%, but African American students continue to be suspended at higher rates.<sup>51</sup>

- Action Item C.1.2:** Provide standard curriculum for teaching certificate and training for all classroom staff about mental health and building resiliency in children, mental illness, signs of suicidal ideation<sup>52</sup> and available supports, the effects of Adverse Childhood Experiences and stigma reduction. Ensure all staff knows what to do and whom to notify as soon as they see a child who may need help.
- Action Item C.1.3:** Provide online resources:  
For educators – on best practices and evidence-informed school based interventions  
For students and parents – Information on children’s mental health and resources in the community
- Action Item C.1.4:** Provide age appropriate education to all Elementary, Middle, and High School students about mental health, mental illness, signs of suicidal ideation and available supports, the effects of Adverse Childhood Experiences and stigma reduction.
- Action Item C.1.5:** Each child with serious mental illness will have an Individualized Education Plan that complements their mental health treatment and recovery plan and is created in consultation with the child’s mental and behavioral health providers and / or the rest of the child’s wraparound team.
- Action Item C.1.6:** Develop and support therapeutic classrooms within comprehensive schools and in special schools / settings.

**An example of a therapeutic classroom is the  
Heartland Therapeutic School in Council Bluffs:**

“Our Therapeutic School, serving southwest Iowa, is a terrific example of the hallmarks of Heartland Family Service: prevention, collaboration and commitment to addressing the community’s most challenging needs. This unique school, serving children with serious academic, emotional, behavioral and cognitive disorders, has received exceptional support from the Council Bluffs Community School District and the school districts it serves through Area Education Agency 13 (AEA 13). The youth are diagnosed with serious psychiatric issues that require certified classroom teachers, master-level social workers, a consulting psychologist and psychiatrist, and other behaviorally-trained staff. In addition to the advantage of allowing these children to remain at home with their families instead of being institutionalized out of town, the School provides a very cost-efficient model for meeting their unique needs. Because there is such a high demand for this service, we moved into a new facility and doubled our student population. Referrals are accepted through the AEA 13 school districts.”<sup>53</sup>

- Action Item C.1.7:** Develop, fund, and implement Case Consultation Model statewide.
- Action Item C.1.8:** Fully fund social workers and counselors at the capacity needed to support children's mental health needs in the school setting.
- Action Item C.1.9:** Appropriate specific funds for these creation and maintenance of above programs in the state budget.

**Operational Objective C.2: Schools as link to community services**

Schools will serve as a critical link to community mental health services.

- Action Item C.2.1 :** Define and communicate the role of the school in providing mental health supports
- Action Item C.2.2:** Train educators on the increased risks untreated mental health problems have for school dropout and entering the juvenile justice system.
- Action Item C.2.3:** Continue Iowa's suicide prevention hotline and other prevention measures.

**The Suicide Epidemic**

"According to the Center for Disease Control, suicide is the third leading cause of death among teenagers in the United States. In Iowa, suicide is the second leading cause of death for this age group. According to the Iowa Youth Survey (2012) 13 percent of Iowa's youth in grades 6, 8, and 11 (or 13,772) reported they have seriously thought about killing themselves within the past twelve months; and 7 percent (or 7,415) of these young people reported they actually developed a plan to do so. Therefore, it is a significant concern that suicide in Iowa among school-age youth is more prevalent than in the nation as a whole."<sup>54</sup>

- Action Item C.2.4:** Build on anti-bullying initiatives with evidence-supported, trauma-informed and restorative-justice based programs.
- Action Item C.2.5:** Continue administering the Iowa Youth Survey, providing guidance to schools in reviewing these data, and developing student supports based on these data through their Comprehensive School Improvement Plans.
- Action Item C.2.6:** Define and communicate guidelines for providing school-based therapy using the UCLA model for school-based therapists and *Best Practices in School-based Mental Health Services: Prepared for Iowa Area Education Agencies*, April 2015.

## **Strategic Objective D: Public Outreach and Education**

### Awareness and Stigma Reduction

#### Operational Objective D.1: Awareness campaign

Statewide Awareness Campaign promoting the mental wellbeing of Iowa's children

- Action Item D.1.1:** The state and local budgets will appropriate specific funds to raise public awareness about children's mental health and the resources available. These funds may be in the form of grants to encourage schools, government agencies and private organizations to create and distribute public service messages.
- Action Item D.1.2:** Collaboration of organizations working on issues relating to children's mental health including (but not limited to) reducing child abuse, preventing suicide, preventing bullying, recognizing mental health problems and knowing how to get help.
- Action Item D.1.3:** Local government agencies will organize mental health awareness events and materials.
- Action Item D.1.4:** Provide mental health awareness and stigma reducing programming in schools (e.g., assemblies).
- Action Item D.1.5:** Provide youth mental health first aid or similar training courses for all organizations that serve children and families, parents, and general public.
- Action Item D.1.6:** Hold community children's mental health awareness and stigma reducing events.
- Action Item D.1.7:** Make mental health and wellness part of Iowa's Healthiest State Initiative.

## II. Compliance with Federal Mandates

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### Strategic Objective E: Mental Health Parity Laws

Iowa will be in full compliance with Insurance Mental Health Parity Laws.

#### Operational Objective E.1: Reimbursement for core services

The core set of services for children is recognized and reimbursed by all forms of public and private insurance in Iowa.

- Action Item E.1.2:** Any managed care organization contracting with the state will be required to cover the core services. Failure to do so will be actionable.
- Action Item E.1.3:** Pass legislation that requires all insurance carriers to cover core services.
- Action Item E.1.4:** Enforce mental health parity laws so that private insurance companies no longer shift their financial responsibility to the Medicaid system.
- Action Item E.1.5:** Fund the study and monitoring of the implementation of parity in all public and private health care coverage in Iowa.
- Action Item E.1.6:** Review and ensure an appropriate and consistent definition of pediatric medical necessity, specifically in regards to mental health, to be utilized by all health plans.

### Strategic Objective F: Olmstead Act

Iowa will be in full compliance with the Olmstead Act.

### **What is the Olmstead Act?**

On June 22, 1999, the United States Supreme Court held in *Olmstead v. L.C.* that unjustified segregation of persons with disabilities constitutes discrimination in violation of title II of the Americans with Disabilities Act. The Court held that public entities must provide community-based services to persons with disabilities when (1) such services are appropriate; (2) the affected persons do not oppose community-based treatment; and (3) community-based services can be reasonably accommodated, taking into account the resources available to the public entity and the needs of others who are receiving disability services from the entity.

The Supreme Court explained that its holding "reflects two evident judgments." First, "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable of or unworthy of participating in community life." Second, "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."<sup>55</sup>

#### **Operational Objective F.1: Child Welfare**

Placement decisions for child welfare will recognize the importance to children's mental health to have a safe, life-long, supportive relationship with a trusted adult and to remain, when possible, in community and / or family they know.

**Action Item F.1.1: Recruit and retain foster family and relative placements.<sup>56</sup>**

**Action Item F.1.2: Support decision-making in Foster Care system to ensure least restrictive placement.<sup>57</sup>**

#### **Operation Objective F.2: Community Services**

Families of Children with serious mental illness will have the support and resources necessary to allow them to keep their children at home in the community without putting their child, themselves, or community at risk of injury, trauma, or detrimental effects to their physical and mental health.



- Action Item F.2.1:** Create, implement, and enforce a standardized statewide process for transitioning from pediatric to adult services to ensure availability and access to core services.
- Action Item F.2.1:** Ensure on-going relationships with programs after discharge to ensure successful transition.
- Action Item F.2.2:** Provide funding to increase the number of qualified respite personnel to allow caregivers to maintain the mental and physical health and wellbeing of themselves and the rest of their family.
- Action Item F.2.3:** Provide incentives for current respite personnel to get certified so they can accept Children's Mental Health Waiver.
- Action Item F.2.4:** Provide information and education to all languages and abilities on caregiver wellbeing and ensure their access to support services for caregivers.
- Action Item F.2.5:** Provide care services for other family members to enable caregiver to focus on person with mental health challenges.
- Action Item F.2.6:** Review and address difficulty in paying costs of services (co-pay, etc.,).
- Action Item F.2.7:** Provide more transportation options.
- Action Item F.2.8:** Provide support groups for caregivers and siblings.

### **Operational Objective F.3: Afterschool Programming**

Children with mental health challenges will have access to affordable, appropriate, supportive enriching programming after school just as peers do.

- Action Item F.3.1:** Provide funding resources to school based after school programs and enrichment opportunities to adapt programming and hire staff to support student and youth experiencing mental health challenges.
- Action Item F.3.2:** Provide training to staff members in Children and Youth Mental Health First Aid so that staff is well prepared to support our children.
- Action Item F.3.3:** Provide training to personnel on inclusion Emphasize that inclusivity is not only good for children with mental health issues / disabilities but all children.
- Action Item F.3.4:** Provide Peer Awareness Training to increase inclusive options.
- Action Item F.3.5:** Provide parents/caretakers with information on agency supports and after school opportunities.

#### **Operational Objective F.4: Summer Programming**

Children with mental health challenges will have access to affordable, appropriate, supportive enriching summer programming just as peers do.

- Action Item F.4.1: Provide extra staff trained in children's mental health to support participants experiencing mental health challenges**
- Action Item F.4.2: Adapt programming to accommodate mental health needs**
- Action Item F.4.3: Provide training to personnel on stigma reduction and inclusion. Emphasize that inclusivity is not only good for children with mental health issues / disabilities but all children.**
- Action Item F.4.4: Provide Peer Awareness Training to increase inclusive options.**
- Action Item F.4.5: Provide parents/caretakers with information on agency supports and summer programming.**

#### **Operational Objective F.5: Day Care**

Children with mental health challenges will have access to affordable, appropriate, supportive enriching daycare programming just as peers do.

- Action Item F.5.1: Provide extra staff to support participants experiencing mental health challenges**
- Action Item F.5.2: Adapt programming to accommodate mental health needs**
- Action Item F.5.3: Provide daycare options for both children under and over 12 years of age with mental health challenges**
- Action Item F.5.4: Provide Peer Awareness Training to increase inclusive options.**
- Action Item F.5.5: Provide parents/caretakers with information on agency supports and daycare opportunities.**

#### **Operational Objective F.6: Recreational Programming**

Children with mental health challenges will have access to affordable, appropriate, supportive community recreational programming

- Action Item F.6.1:** Encourage or establish policies that include programs and accommodations for people with mental health and other disabilities.
- Action Item F.6.2:** Adopt policy to ask participants about interests, showing what's available within a school and community, and then finding suitable matches.
- Action Item F.6.3:** Adopt policy of taking into account IEP, service provider records, and other information about participants if possible to promote success.
- Action Item F.6.4:** Partner with community resources - both mental health services and things like Senior Citizens, Lion's Club, Rotary Club can be useful places to do trial recreational or leisure activities
- Action Item F.6.4:** Provide Peer Awareness Training to increase inclusive options.
- Action Item F.6.5:** Provide parents/caretakers with information on agency supports and community recreational opportunities.

#### **Operative Objective F.7: Social Skills**

Children with mental health needs will receive the support they need to learn and practice social skills in the community.

- Action Item F.7.1:** Include in-community Social Skills Training to children with mental health challenges as a core service covered by all health care insurance (public and private).
- Action Item F.7.2:** Provide parenting education on social skill development and support to parents

### **Strategic Objective G: Child Find**

Iowa will be in full Compliance with Child Find.

#### **What is Child Find?**

The Child Find mandate is in the Individuals with Disabilities Education Act. It states:

“The State must have in effect policies and procedures to ensure that--

- (i) All children with disabilities residing in the State, including children with disabilities who are homeless children or are wards of the State, and children with disabilities attending private schools, regardless of the severity of their disability, and who are in need of special education and related services, are identified, located, and evaluated; and
- (ii) A practical method is developed and implemented to determine which children are currently receiving needed special education and related services.”<sup>58</sup>

### Operational Objective G.1: Mental Health Screening in schools

Schools will provide age appropriate mental health screening at key points during the child's development (as it currently does for physical health issues like scoliosis, hearing or vision loss).

**Action Item G.1.1: Determine which screening tools will be used at which grade levels.**

**Action Item G.1.2: Determine protocol for referral to community services.**

**Action Item G.1.3: Fund training and implementation of program.**

## Strategic Objective H: Early Periodic Screening Diagnosis and Treatment

Iowa will be in full compliance with EPSDT.<sup>59</sup>

### What is EPSDT?

A Federal Mandate for all states to provide comprehensive services and furnish all Medicaid coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions. EPSDT requires the state to provide screening, diagnostic, and treatment services, for all children who are on Medicaid or enrolled in CHIP. State Medicaid agencies are required by law to

- Inform all Medicaid-eligible individuals under age 21 that EPSDT services are available
- Provide or arrange for the provision of screening services for all children
- Arrange (directly or through referral) for corrective treatment as determined by child health screenings
- ***"States are required* to provide any additional health care services that are coverable under the Federal Medicaid program and found to be medically necessary to treat, correct or reduce illnesses and conditions discovered ***regardless of whether the service is covered in a state's Medicaid plan***. It is the responsibility of states to determine medical necessity on a case-by-case basis."**
- This mandate explicitly includes periodic mental health and developmental screening and treatment ***at intervals that meet reasonable standards*** of medical practice. ***"States must consult with recognized medical organizations* involved in child health care in developing their schedules."<sup>60</sup>**

### Operational Objective H.1: Bring Iowa's broken Medicaid HCBS Waiver system

- Action Item H.1.1:** All children in Iowa on Medicaid will have immediate access to all services covered under EPSDT.
- Action Item H.1.2:** All children in Iowa medically eligible for a Medicaid Health Waivers will have immediate access to all services covered under EPSDT.
- Action Item H.1.3:** Streamline the Medicaid Waiver process to eliminate waiting lists and ensure screening within weeks of application.

#### **Iowa's Medicaid Waiver Waiting Lists**

The waiting lists for the Children's Mental Health Waiver and Brain Injury Waiver<sup>61</sup> are close to three years long. The number of children on these waiting lists has consistently continued to grow. Further, Iowa has recently made a waiting list for children with Intellectual Disabilities (who until recently did not have a waiting list).

Three years without treatment for a child with developmental and mental health disorders overwhelmingly reduces chances of recovery without lifelong disability and spirals youth into a lost childhood of preventable hospitalizations and institutional placements.

- Action Item H.1.4:** Streamline the Medicaid Waiver system so that children with co-morbid conditions (e.g., intellectual disabilities and mental health disabilities) can receive all needed services. The system should treat the whole child and recognize the artificial nature of waiver categories in practice.
- Action Item H.1.5:** Waivers will include services for children on the Autism Spectrum. (Who are not currently covered unless they qualify through a co-morbid condition.)
- Action Item H.1.6:** Iowa will ensure that every Managed Care Organization that it contracts with to provide Medicaid services is in compliance with this and other Federal Laws, as the state is accountable despite these contracts.

## **Strategic Objective I: Juvenile Justice and Delinquency Prevention Act**

Iowa will be in full compliance with the JJDP Act.

### **What is the JJDP Act?<sup>62</sup>**

“The federal JJDP Act contains four requirements: deinstitutionalization of status offenders; sight and sound separation; jail removal and disproportionate minority confinement.”

1. The Deinstitutionalization of Status Offenders (DSO) requires that juveniles who are charged with status offenses, or offenses that would not be criminal if committed by an adult (truancy, running away, possession of alcohol or tobacco, etc.), cannot be placed in secure detention facilities or secure correctional facilities.
2. Sight and sound separation requires that juveniles not be detained in facilities where they have regular contact with adult prisoners.
3. The Juvenile Justice and Delinquency Prevention Act of 1974 as amended requires that states assess and address the issue of the disproportionate minority confinement in secure facilities.

### **How is Iowa Doing?**

“An intensive study, conducted by Dr. Michael Leiber, University of Northern Iowa, The Disproportionate Overrepresentation of Minority Youth in Secure Facilities: A Survey of Decision Makers and Delinquents, as well as other activities completed in Iowa, determined that:

- Minority youth are disproportionately over-represented in secure facilities and within Iowa’s juvenile justice system.
- Race was a factor contributing to this overrepresentation:
  - legal factors have much stronger impact than race
  - subtle/unintentional bias, not blatant racism, is the problem
  - effect of race on decision-making varied by race, community and the stage of juvenile court processing
  - eliminating race bias in juvenile court processing, alone, will not eliminate overrepresentation
- Overrepresentation in the system is largely due to social and community situations outside the justice system.
- There is little minority input in the development of system policies and programs.
- There are few minority persons working within the system.<sup>63</sup>

**Operative Objective I.1: Eliminate by 2020 the disproportionate minority confinement of youth in Iowa.**<sup>64</sup>

- Action Item I.1.1:** Immediately create, fund, and support a multi-level interagency task force to implement programs to reduce disproportionate minority confinement with the goal of elimination by the year 2020. This task force must facilitate real cooperation within the system and among agencies. Examples of programs include prevention programs, Rites of Passage programs, diversion, in-home detention, mentoring, etc. The
- Action Item I.1.2:** Launch a public outreach campaign on children's mental health and available resources to minority populations.
- Action Item I.1.3:** Screen any child in contact with the Juvenile Justice system for Mental Illness, Developmental Disorders, and Adverse Childhood Experiences and refer children to proper medical services rather than incarcerate.
- Action Item I.1.4:** Launch statewide cultural competency training for all juvenile justice, court, and Department of Human Services staff, etc., that work with children at risk for or who have come into contact with the juvenile justice system.

"Culturally appropriate programming for the population the program is to serve. This includes history, respect of language, religious and cultural differences, etc. Discussion should be provided that identifies how the unique needs of youth will be met."<sup>65</sup>

**Operative Objective I.2: Provide Gender Specific Programming**

Be in full compliance with the 1992 Reauthorization of the JJDP Act, which requires specific steps to address the systemic issue of gender bias.

"The steps include a requirement that states analyze gender specific services and develop a plan for providing needed gender specific services for the prevention and treatment of juvenile delinquency. All applicants will be evaluated on the extent to which the strategy specifically utilizes gender specific programming and reflects the needs and issues of girls or assists in providing information on the needs and issues of girls. Providing gender specific programs and services is needed in all funding categories."<sup>66</sup>

### **Why Gender Specific Programming is needed<sup>67</sup>**

“There is a great deal of research that documents the need to provide services specifically for girls. These services must be more than ones which merely target the young women at-risk. They are instead, ones which meet the standard of being both specific to the female experience and free from gender bias. Using this rationale, any program that attempts to serve young women must:

- meet the unique needs of females
- value the female perspective
- honor the female experience
- celebrate the contributions of girls and women
- respect female development
- empower girls and young women to reach their full human potential
- work to change established attitudes that prevent or discourage girls and young women from recognizing that potential

Careful examination of everything we do in girls’ programs is needed, including: the education materials, the discipline system, the rules and norms, the treatment modalities, the relationships, program activities and the general program environment and culture. When considering whether gender specific programming is necessary, it is important to know that:

- Boys form their identity primarily in relation to the greater world. This means that they are interested in the rules of that world, their place in the structure of that world and how to move ahead or gain power within that structure.
- Girls form their identity primarily in relation to other people. This means that they are interested in what “relationship” means and how it works. They define themselves through those to whom they relate and by how well they get along with those people.

#### Research shows:

- Programs for boys are more successful when they focus on rules and offer way to advance within a structured environment.
- Programs for girls are more successful when they focus on relationships with other people and offer ways to master their lives while keeping these relationships in tact.

Some programs are designed initially for boys and when adapted for girls are not successful since their underlying assumptions do not lead to strong, healthy female development. In cases where programs have been designed for male adolescents, it is necessary to make changes that:

- Allow more opportunity for the building of trusting relationships.
- Offer learning experiences and skill building after these relationships have been established.
- Allow girls the safety and comfort of same-gender environments.
- Help girls understand that they can be professionally and emotionally successful in life and still have strong relationships.”



- Action Item I.2.1:** Study and make public report of the current condition of gender bias, including bias against LGBTQ youth. If current measures are not in place to get this data, create new measures that will.
- Action Item I.2.2:** Study and make public report of the impact of the closing of the Toledo Juvenile Home on gender disparities and what to date has been done to address them.
- Action Item I.2.3:** Creative preventive programming that empowers and builds up the resiliency and wellness of girls and LGBTQ youth.

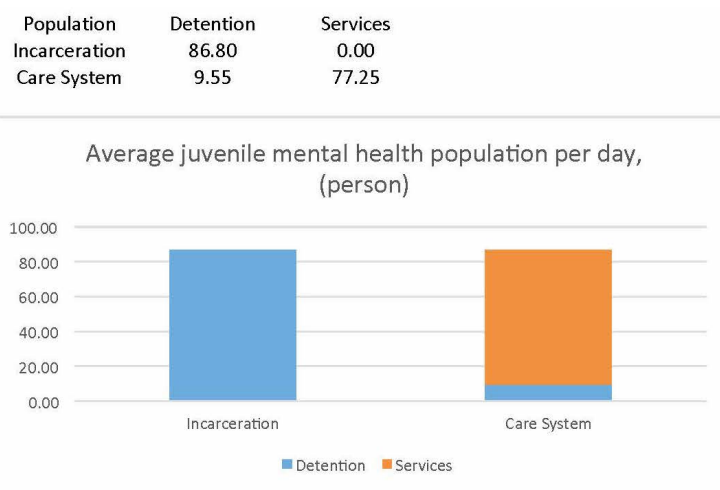
### III. Stop Criminalization of Mental Illness

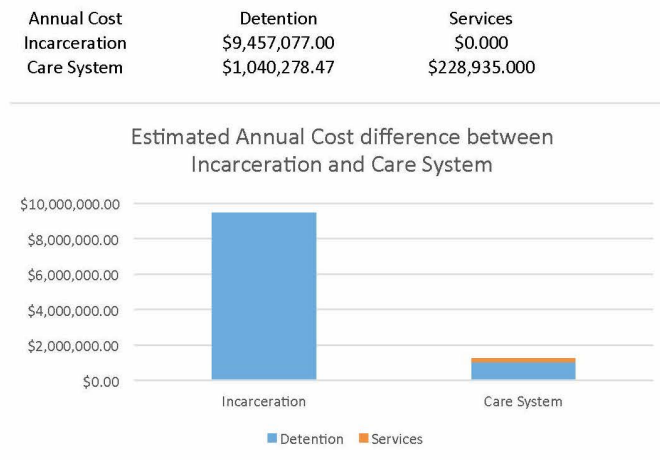
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**Students with disabilities (served by IDEA) represent 25% of students arrested and referred to law enforcement, even though they are only 13% of the overall student population.<sup>68</sup>**

**In Iowa that amounts to approximately 4,513 children with disabilities arrested per year.<sup>69</sup>**

**The price tag to the state of Iowa to incarcerate youth with mental illness exceeds \$9.4 million annually. Providing wraparound services through system of care programs for the same number of youth and their families would cost an estimated \$229 thousand annually, a return on investment of up to \$40.31 for every dollar invested in wraparound care.<sup>70</sup>**





## Strategic Objective J: Crisis Services

Families with children in mental health crisis have immediate access to resources necessary to end crises with positive outcomes.

Children with developmental and mental health disabilities often have additional challenges during emergency situations that can complicate their access to needed services. It is very important to have programs and policies that provide these children, their families, and First Responders the tools to most effectively maintain safety in their communities. Having such supports is key to making it possible for many children to live with their families, to avoid injury or death, to avoid institutionalization, and to avoid becoming part of the juvenile justice system. (For more information, see Appendix I.)

### Operational Objective J.1: Safety Services

Critical services for safety of children with developmental and mental health needs will be accessible in all Iowa communities.

**Action Item J.1.1: Develop and implement a coordinated response plan for wandering or elopement.**

**Wandering / Elopement** – Wandering, also called elopement, is when someone leaves a safe area or responsible caregiver. This behavior is common in children with developmental and intellectual disabilities and typically includes situations where the child may be harmed or injured as a result.<sup>71</sup>

### **Missing Children With Special Needs**

“Finding and safely recovering a missing child with special needs often presents a unique and difficult challenge for families, law enforcement, first responders, and search teams. The behaviors and actions of a missing child with special needs are often much different than those of a missing non-affected child. While the behaviors will differ from child-to-child, missing children with certain special needs may:

- Wander away, run away, or bolt from a safe environment
- Exhibit a diminished sense of fear causing them to engage in high-risk behavior such as seeking water or active roadways
- Elude or hide from search teams
- Seek small or tightly enclosed spaces concealing themselves from search teams
- Be unable to respond to rescuers A special-needs condition may be characterized by debilitating physical impairments, social impairments, cognitive impairments, or communication challenges

**This passage is quoted from “Missing Children with Special Needs Addendum-1” at [http://www.missingkids.com/en\\_US/publications/SpecialNeeds\\_Addendum.pdf](http://www.missingkids.com/en_US/publications/SpecialNeeds_Addendum.pdf)**

### **Statistics:**

- Eloping (wandering) is among the most stressful autism behaviors for parents. Half of families with elopers report they had never received advice or guidance about elopement from a professional.<sup>72</sup>
- 49%, of children with autism attempt to elope from a safe environment, a rate nearly four times higher than their unaffected siblings.<sup>73</sup>
- Increased risks are associated with autism severity.<sup>74</sup> More than one third of children with autism who elope cannot communicate their name, address, or phone number.<sup>75</sup>
- 65% of elopers have a “close call” with a traffic injury and 32% with a possible drowning.<sup>76</sup>
- From 2009 to 2011, accidental drowning accounted for 91% total U.S. deaths reported in children with autism ages 14 and younger subsequent to elopement. Sixty-eight percent of these deaths happened in a nearby pond, lake, creek or river.<sup>77</sup>

### **Resources for families and first responders:**

- AWAARE <http://awaare.nationalautismassociation.org/>  
Caregiver toolkit:  
<http://nationalautismassociation.org/docs/BigRedSafetyToolkit.pdf>

First Responder toolkit:

<http://nationalautismassociation.org/docs/BigRedSafetyToolkit-FR.pdf>

- Safe & Sound: Autism Society: <http://www.autism-society.org/living-with-autism/how-the-autism-society-can-help/safe-and-sound/>
- Tanager Place Autism Spectrum Disorder (ASD) Emergency Planning Parent/Family Tip Sheet: <http://www.tanagerplace.org/wp-content/uploads/2013/11/ASD-Safety-Packet-PDF-File.pdf>

**Action Item J.1.2: Fund and implement *statewide* service to provide first responders key information about child's disability that will help them respond effectively to emergencies.**

- Some areas in Iowa already contract with private companies (such as Smart911<sup>78</sup>) to provide such services. Not all areas in Iowa, particularly rural areas, currently have this service. Statewide service ensures that all children have this critical protection.<sup>79</sup>
- The State of Maine has a very effective program that includes training all law enforcement on how to interact with autistic people and those with other differences, and a statewide registration system that can be tagged with license plate, name, address, and other identifying factors. It can include a wide range of information including behavior, communication ability, languages, physical differences, etc. Iowa can replicate this program. [http://www.asmonline.org/programs\\_law.asp](http://www.asmonline.org/programs_law.asp)

**Action Item J.1.3: Provide mental health supports for children during and after emergency calls (fire, medical crisis of caregiver, etc.,).**

**Action Item J.1.2: Implement mobile crisis units across Iowa**

**Action Item J.1.3: Make emergency respite care available throughout Iowa**

### **Operational Objective J.2: Positive Interactions**

All children will have safe and positive interactions with first responders.

Children with mental illness often behave in unexpected ways that can be misinterpreted if the First Responder is not aware of their condition:

- Heightened anxiety and depressions in children can lead to behavior that is or appears aggressive or violent.
- Depression can lead to suicide or self-harm.
- Mania and psychosis can lead to risky behaviors that result in injury or death.

- Action Item J.2.1:** Train first responders on safe and effective interaction with children with developmental and/or mental health disabilities.
- Action Item J.2.2:** Provide children with disabilities proactive positive interactions/experiences with first responders and equipment.
- Action Item J.2.3:** Develop and deliver training for youth and caregivers on safety, self-advocacy, and appropriate interactions with first responders and law enforcement.
- Action Item J.2.4:** Implement statewide ID card program that identifies disabilities, triggers, and other helpful information particular to the child to help first responders understand non-typical responses or behaviors.
- Action Item J.2.5:** Implement awareness campaign about services.

### **Strategic Objective K: Stop the Prison Pipeline**

All schools and communities in Iowa will discontinue what are known as “Prison Pipeline” policies and practices that push school children out of school and into the juvenile and criminal justice systems. These policies disproportionately harm children who belong to racial and ethnic minority groups, children in foster care, and children with serious mental illness.

*The School to Prison Pipeline describes policies and practices that push school children, particularly our most at-risk children, out of schools and into the juvenile and criminal justice systems. Restorative Practices in schools and communities, early intervention and intensive treatment programs will save Iowa money by reducing school dropout, drug abuse, crime, incarceration and homelessness.*

“95% of youth in the juvenile justice system have committed *non-violent* offenses.”<sup>80</sup>

Children with serious mental illness are twice as likely as other students to be arrested before leaving school.<sup>81</sup>

Nearly half of girls and nearly one third of boys in the juvenile justice system have experienced 5 or more ACEs.<sup>82</sup>

## **What Policies and Practices Contribute to the Prison Pipeline?**

**Zero Tolerance Policies** include mandatory suspension or expulsion and increased reliance on school resource officers and police rather than teachers and administrators to maintain discipline, resulting in school-based arrests.

- These policies emerged in the mid-1990s and were originally focused on guns in schools, and later drugs and violent crime. However, since then many schools nationwide have come to rely on mandatory suspensions as the *primary or exclusive* means to address a significantly wider range of behavior issues, including minor infractions such as talking back to the teacher.<sup>83</sup>
- These policies are not applied equally. Students with disabilities, foster children, and students of color or overrepresented.
- Studies are now showing that not only are the Zero Tolerance Policies ineffective, but they lead to greater disengagement and dropout rates.<sup>84</sup> “Moreover, the feelings of exclusion and stigma among suspended students can pave the way for more misbehavior and further suspensions in what can become a negative downward spiral. Research shows that students who arrive in 9th grade under-skilled and/or overage from being held back are most likely to drop out.<sup>70</sup> A student interviewed by the Center for Community Alternatives offered a sobering analysis of the cumulative impact of suspensions on student behavior: ‘It makes people feel like they can’t do nothing with their life. They just drop out’”.<sup>85</sup>
- Once involved in the juvenile or criminal justice systems, re-entry to traditional schools often not possible.
- (See III.C.3 for alternatives to Zero Tolerance Policies.)

**Underfunding of Schools** has severe consequences for the most vulnerable children.

- The insufficient funding for counselors, special education services and training for staff in children’s mental health create a dangerous environment for children with serious mental illness.
- Inadequate resources in public schools, such as overcrowded classrooms, a lack of qualified teachers and up-to-date textbooks and equipment lock students into second-rate education environments. Students get the message that their futures do not matter.
- Such educational disadvantages make it more likely that children will enter the juvenile justice system.
- This spending policy is not consistent with Iowa’s stated goal to have the best schools in the nation. (As it currently stands, Iowa has one of the widest gaps between success rates of students in general and special education.)

## **Who does the Prison Pipeline Harm?**

### **Children with serious mental illness**

- 79% of Iowa students subject to physical restraint have disabilities (IDEA), yet students with disabilities only make up 12% of the school population.<sup>86</sup>
- 10 % of students with disabilities (IDEA) suspended from Iowa schools in 2011-2012 (compared to 3% of children without disabilities).<sup>87</sup>
- Students who are suspended or expelled are more likely to drop out of school.<sup>88</sup>
- 50% of students with serious mental illness age 14 and older drop out of high school.<sup>89</sup>
- “Children with mental illness are twice as likely to be living in a correctional facility, halfway house, drug treatment center, or ‘on the street’ after leaving school compared to students with other disabilities.”<sup>90</sup>
- 73% of youth with serious mental illness who drop out of school are arrested within five years.”<sup>91</sup>

### **Minority Children**

- Students who are suspended or expelled are more likely to drop out of school. During the 2011-2012 school year, Iowa students receiving at least one out-of-school detention:
  - 18% of African American males compared to 4% white males.<sup>92</sup>
  - 12% of African American females compared to 2% white females.<sup>93</sup>
 Whereas, only 4.2% of Iowa children in 2012 were African American, 80.6% were white).<sup>94</sup>
- 70% of U.S. students involved in “in-school” arrests or referred to law enforcement are African American or Latino.<sup>95</sup>
- 729 Iowa children and youth were in residential placement in 2011. 22 % of the children in residential placement were African American, 10 percent were Hispanic, and 61 % were White.<sup>96</sup>

### **Children with Multiple ACEs (Adverse Childhood Experiences):**

- 93% of males and 84% of females in juvenile detention reported a Adverse Childhood Experience (ACE)<sup>97</sup>
- 57.7% of high school dropouts have 4 or more ACEs.<sup>98</sup>
- 27.4% of males and 45.1% of females of juvenile justice offenders have experienced 5 or more ACEs. The average composite ACE score for female juvenile justice offenders is 4.29 and 3.48 for males.<sup>99</sup>
- 48.3% of adult offenders experienced 4 or more aces (compared with 12.55% of the general population.)<sup>100</sup>
- For each type of traumatic event reported by a child, the risk of that child to perpetuate violence increases from 35% to 144%.<sup>101</sup>

### Foster Children

- 70% of U.S. Foster Care Youth entering the Juvenile Justice system are **not** placement-related behavioral cases.<sup>102</sup>
- 25% of young people leaving Foster care will be incarcerated within a few years after turning 18.<sup>103</sup>
- 50% of children in the foster care system are African American or Latino.<sup>104</sup>
- 50% of young people leaving foster care will be unemployed within a few years after turning 18.<sup>105</sup>
- 19% of Iowa's foster children are placed in group care or institutions compared to the national average of 14%.<sup>106</sup>
- More than 40% of Iowa children in group-placements had no mental health diagnosis, medical disability, or behavior problem.<sup>107</sup>
- Children placed in group care settings are more likely to test below average in English and math, drop out of school, and be arrested compared to similar youth living with foster families. They also are at greater risk to be victims of physical abuse.<sup>108</sup>

### Operational Objective K.1: End Zero Tolerance Policies

Replace Zero Tolerance policies with restorative practices in schools and communities.<sup>109</sup>

#### What are Restorative Practices?

- "Restorative Practices see conflict or bad behavior as opportunities to teach students about the effects of their behavior and the repercussions for the victim and wider community, thereby creating empathy and motivating change in future behavior."<sup>110</sup>
- "Restorative practices recognize that when a wrong has been committed, the offender needs to be re-integrated back into the community to avoid alienation, which, as discussed previously, could also lead to repeat offending. To do so, the offender must be held accountable. This requires acknowledging the true consequences of their behavior through supervised face-to-face encounters with the people they have harmed.<sup>111</sup> The final step is to repair the harm created by their act and have a plan for how to ensure that the offense will not be repeated. There is no "right" answer to how to do this. Rather it is the process of working together to heal the harm that leads to true accountability and makes a response restorative or not."<sup>112</sup>
- "Restorative practices focus on building community and relationships that will reduce and prevent undesired behaviors. They can be formal or informal processes, but tend to take place before a wrong occurs (as opposed to "Restorative Justice", a subset of restorative practices, that can only occur after an incident occurs."<sup>113</sup>
- Restorative practices can include conflict resolution, peer mediation and community arrangements with outside mediators.
-



**Research shows that punitive zero tolerance discipline approaches do *not* prevent or reduce misbehavior, but have *negative* effects on learning:<sup>114</sup>**

- Denver Public Schools adopted new discipline policies in 2008-2009 that use restorative justice, resulting in a 68% reduction in police tickets in schools and a 40% reduction in out-of-school suspensions.<sup>115</sup>
- West Philadelphia High School was on the state’s “Persistently Dangerous Schools” list for six years. But after one year of implementing restorative practices, the climate has improved dramatically:
  - Suspensions were down by 50% in the 2007-2008 school year,<sup>116</sup> and
  - Violent acts and serious incidents dropped 52% in 2007–2008, and another 40% by Dec 2008.<sup>117</sup>
- Chicago Public Schools adopted a new student code of conduct in 2006 incorporating restorative practices. Over 50 high schools in Chicago now have restorative peer jury programs. As a result:
  - Over 1,000 days of suspension were avoided in 2007-2008 by referring students to peer jury programs for violating school rules, keeping them in the learning environment,”<sup>118</sup>
  - At Dyett High School, student rates decreased by 83% one year after implementing a restorative peer jury program.<sup>119</sup>

**Action Item K.1.1      Decrease overall physical restraint and seclusion rates and monitor, report and eliminate disparities with physical restraint rates.**

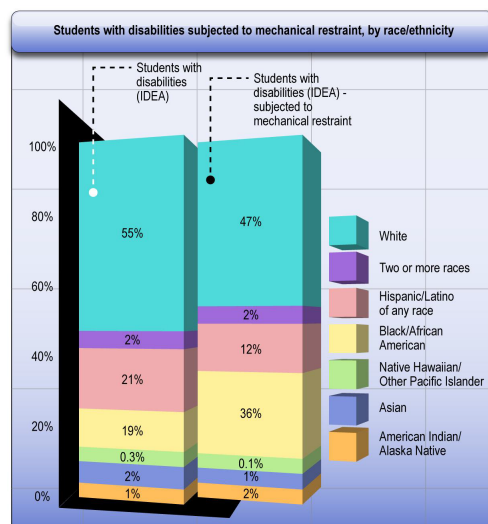
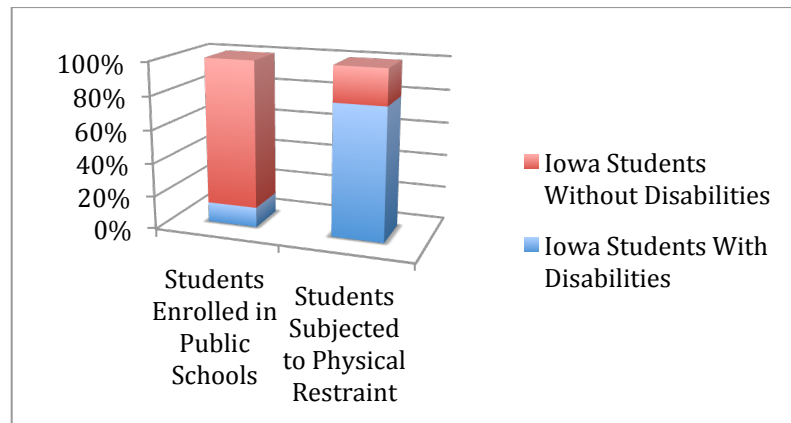
**Restraint and Seclusion**

**What is Restraint?**

“Mechanical restraint is the use of any device or equipment to restrict a student’s freedom of movement. Physical restraint is a personal restriction that immobilizes or reduces the ability of a student to move his or her torso, arms, legs, or head freely.”<sup>120</sup>

### Disparities in the Use of Restraint

**By disability status:** Iowa students with disabilities (IDEA) represent 12% of the student population, but 79% of those are physically restrained at school to immobilize them or reduce their ability to move freely.<sup>121</sup>



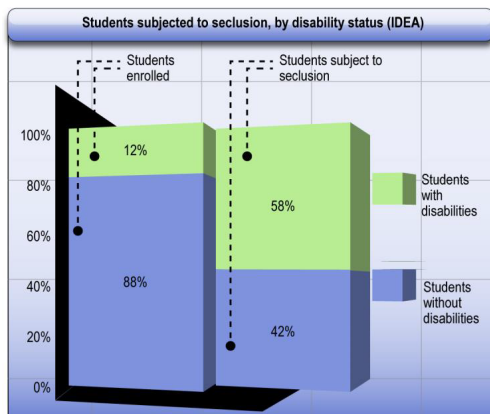
### **Of students with disabilities by race / ethnicity:**

While African American students represent only 19% of U.S. students with disabilities served by IDEA, they represent 36% of U.S. students with disabilities subject to mechanical restraint, a ratio of almost 2:1. (NOTE: Detail may not sum to 100% due to rounding. Figure represents 99% of CRDC responding schools, including 6 million students served by IDEA and nearly 4,000 IDEA students subject to mechanical restraint.)<sup>122</sup>

Given the racial/ethnic disparities in Iowa incarceration rates, it is important to gather data by race, gender, and disability status on the use of school disciplinary practices that push children out of the classroom in *Iowa*.

**What is Seclusion?** “Seclusion is the involuntary confinement of a student alone in a room or area that the student is physically prevented from leaving.”<sup>123</sup>

### Disparities in the use of Seclusion:

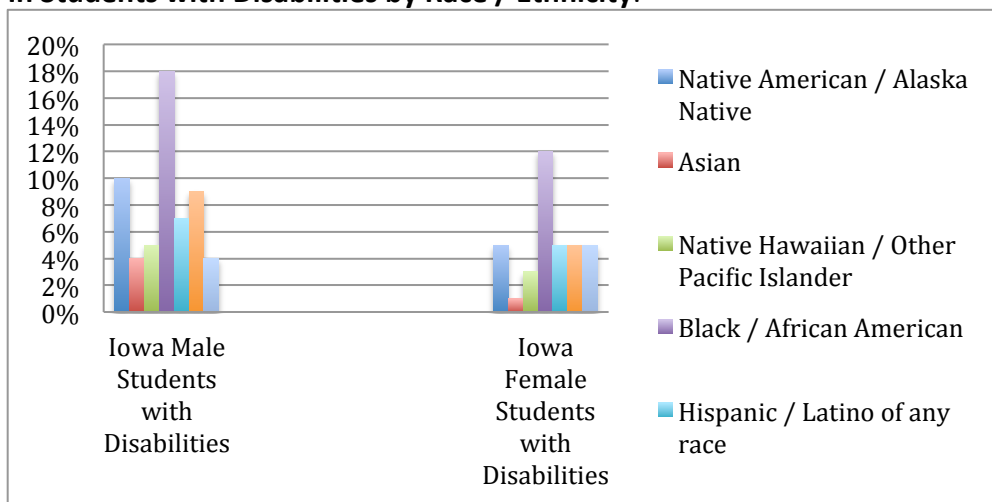


**By disability status:** U.S. students with disabilities (IDEA) represent 12% of the U.S. student population, yet they make up more than half of students placed in seclusion or involuntary confinement. (**NOTE:** Detail may not sum to 100% due to rounding. Figure represents 99% of schools, including 49.7 million students enrolled and over 37,000 students subject to seclusion.)<sup>124</sup>

**Action Item J.1.2: Decrease overall suspension rates and eliminate disparities in rates.**

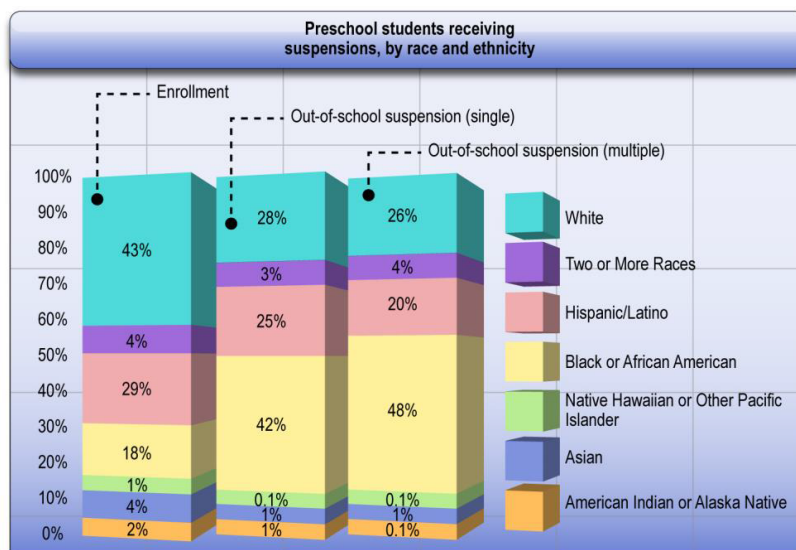
### Disparities in the use of Out-of-School Suspension:

#### **In Students with Disabilities by Race / Ethnicity:**



“With the exception of Latino and Asian-American students, more than one out of four U.S. boys of color with disabilities (served by IDEA) — and nearly one in five U.S. girls of color with disabilities — receives an out-of-school suspension.”<sup>125</sup>

**Disturbingly, this disparity begins early:<sup>126</sup>**



- Action Item K.1.3:** Provide peer mediation training with students in a selective review process
- Action Item K.1.4:** Connect schools and community partners to provide third party mediators.
- Action Item K.1.5:** Build community capacity by training school resource officers and other community partners in conflict resolution, about behaviors that occur with developmental disabilities and mental illness, and trauma sensitive ways to intervene.<sup>127</sup> A 2012 analysis of such a program, called “Communities that Care”, show that highly effective implementation results in \$5.30 in savings for each dollar of implementation cost.<sup>128</sup>
- Action Item K.1.6:** Track use, fidelity and effectiveness of practices. Involve school nurses, counselors, and social workers in the tracking process.

### **Operational Objective K.2: Track disparities**

Determine measures to better understand disparities in education and juvenile justice and monitor outcomes of policies

- Action Item K.2.1:** Provide training to schools and juvenile justice system staff about disparities in education and juvenile justice for adolescents with mental health needs.
- Action Item K.2.2:** Establish accountability measures to monitor outcomes in education and juvenile justice system.

**Operational Objective K.3: Report disparities**

Compile publicly available annual district reports of the total number of disciplinary actions that push children out of the classroom.

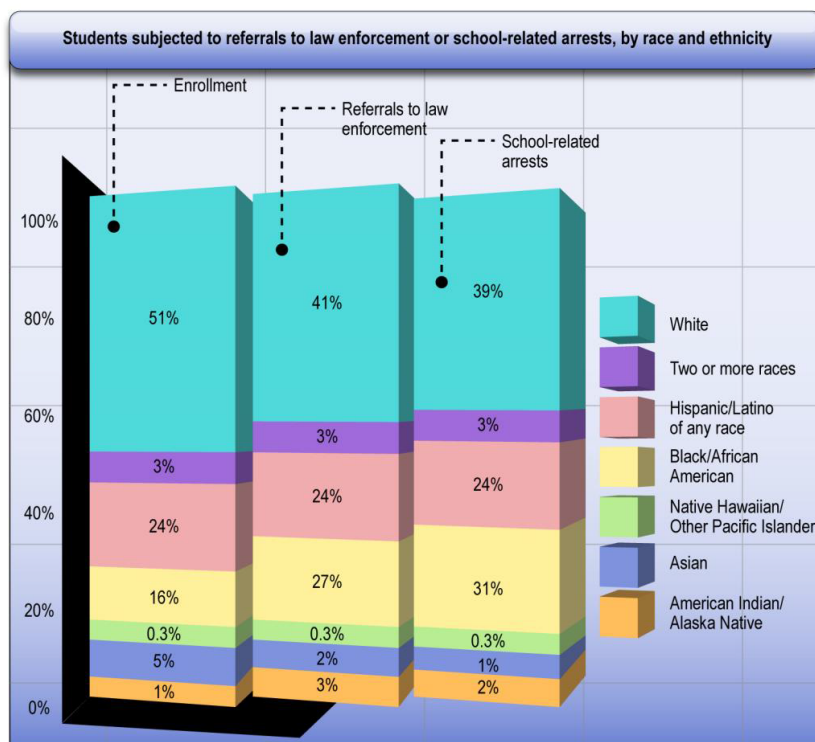
- Action Item K.3.1:** Assess the level of current policies and disciplinary procedures in schools that force children out of classroom.
- Action Item K.3.2:** Compile publicly available report on disciplinary methods used in schools such as detention, suspension (in or out of school), placement in Behavioral Disorder Classroom, other special education placements, restraint and seclusion, in-school arrests and the like.
- Action Item K.3.3:** Compile publicly available report on disciplinary methods that is aggregated by gender, race/ ethnicity, age, ability and mental health status
- Action Item K.3.4:** Research and compile publicly available report on how many families decide to homeschool their children because of student's mental health needs
- Action Item K.3.5:** Monitor and report on agreed upon outcome measures reflecting the disciplinary actions that push children out of the classroom
- Action Item K.3.6:** Make accessible and transparent public report of the overall progress of the state in achieving the desired disciplinary policies in schools

**Operational Objective K.4: Eliminate Disparities**

Eliminate racial and ethnic bias in the educational system.

### Disparities in Arrest Rates

While African American students represent 16% of student enrollment, they represent 27% of students referred to law enforcement and 31% of students subjected to a school-related arrest. In comparison, white students represent 51% of enrollment, 41% of students referred to law enforcement, and 39% of those arrested.<sup>129</sup>



**NOTE:** Detail may not sum to 100% due to rounding. Totals are 49 million students for overall enrollment, 260,000 students referred to law enforcement, and 92,000 students subject to school-related arrests. Data on referrals to law enforcement represents 98% of schools and data on school related arrests represents 94% of schools in the CRDC universe.

**SOURCE:** U.S. Department of Education, Office for Civil Rights, Civil Rights Data Collection, 2011–12. (U.S. Department of Education Office for Civil Rights 1 Civil Rights Data Collection: Data Snapshot (School Discipline) March 21, 2014, page 6.)

- Action Item K.4.1:** Determine standardized cultural competence training for all working with or on behalf of children in the educational system.
- Action Item K.4.2:** Fund standardized cultural competence training for all working with or on behalf of children in the educational system.
- Action Item K.4.1:** Mandate standardized cultural competence training for all working with or on behalf of children in the educational system.

## **Strategic Objective L: End Criminalization**

Improve Juvenile Justice System to eliminate the criminalization of mental illness.

### **Operational Objective L.1: Crisis Intervention Team (CIT)**

Crisis Intervention Team (CIT)<sup>130</sup> Programs for Youth will be available in every Iowa Police Department.

- Action Item L.1.1:** Identify the guidelines on NAMI 2001 document: “Responding to youth with Mental Health Needs: A CIT for Youth Implementation Manual”.
- Action Item L.1.2:** Collaborate with existing and emerging adult CIT programs to determine resources available and needed to implement CIT.
- Action Item L.1.3:** Mandate and fund local Crisis Intervention Team (CIT) Programs for Youth in every Iowa Police Department.
- Action Item L.1.4:** Implement local Crisis Intervention Team (CIT) Programs for Youth in every Iowa Police Department.

### **Operational Objective L.2: Treatment over incarceration**

Eliminate incarceration for manifestations of disability or substance abuse and replace with mandatory treatment.

- Action Item L.2.1:** Create Mental Health Courts for Youth.
- Action Item L.2.2:** Provide children’s mental health and ACEs<sup>131</sup> training for all working with or on behalf of children in juvenile justice system, including judges and court staff.
- Action Item L.2.3:** Mandate that all state laws regarding age of majority and sentencing must take into account: 1) Human brains are not fully developed until the mid-twenties\* and incarceration negatively effects that development causing great occurrence of later criminality; 2) The emotional / social / developmental and intellectual (rather than the chronological) age of the particular child\*; 3) The child’s particular ACEs and need for trauma-informed care.
- Action Item L.2.4:** Implement statewide program: Youth Mental Health Advocates for children with disabilities that would consult on decisions made about child to protect from re-traumatizing child.
- Action Item L.2.5:** Decrease pre-trial detention of youth with cite and release programs.

## **Strategic Objective M: Decrease Arrests**

Decrease arrests for manifestations of disability and / or substance abuse.

### **Operational Objective M.1: Advocate Presence at Reading of Rights**

Statewide arrest policy for youth with any cognitive or brain disorder, diagnosed or reported by parent, guardian, or mental health advocate: rights must be read to them with a parent / guardian and / or mental health advocate present, with the adult responding, not the child.

**Action Item M.1.1: Create arrest policy based on best practices informed by children's mental health research.**

**Action Item M.1.2: Mandate determined arrest policy in Iowa Code.**

**Action Item M.1.3: Enforce determined arrest policy.**

### **Operational Objective L.2: Diversion**

Youth arrested for drug related offenses will receive mental health screening and be diverted to treatment for mental illness and / or drug abuse.

**Action Item M.2.1: Create standard age-appropriate mental health screening tools for everyone arrested under the age of 26.**

**Action Item M.2.2: Fund mental health screening training and program in all Iowa Police Departments.**

**Action Item M.2.3: Implement mental health screening for everyone arrested under the age of 26.**

**Action Item M.2.4: Mandate mental health screening for everyone arrested under the age of 26.**

## **Strategic Objective N: Medically Appropriate Detention**

Any use of Juvenile Detention must be medically appropriate for the individual child's mental and physical health status.

### **Operational Objective N.1: Staff training**

Each staff member working with or on behalf of child must have training about the particular disorder and understand and implement medically appropriate accommodations for that child (even if they go against general policies and procedures).



- Action Item N.1.1:** Create standard training for all staff in Juvenile Detention facilities working with or on behalf of children in appropriate accommodations for various disabilities and mental and physical health conditions.
- Action Item N.1.2:** Fund and Implement standard training for all staff in Juvenile Detention facilities working with or on behalf of children in appropriate accommodations for various disabilities and mental and physical health conditions.
- Action Item N.1.3:** Fund and implement program that provides medical consultation services to help Juvenile Detention facilities to understand and meet the needs of child given their particular health status.

## Endnotes

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<sup>1</sup> Center for Disease Control, “Suicide Trends Among Persons Aged 10–24 Years — United

<sup>2</sup> Jeffrey A. Bridge, PhD; Lindsey Asti, MPH; Lisa M. Horowitz, PhD, MPH; Joel B. Greenhouse, PhD; Cynthia A. Fontanella, PhD; Arielle H. Sheftall, PhD; Kelly J. Kelleher, MD; John V. Campo, MD, “Suicide Trends Among Elementary School–Aged Children in the United States From 1993 to 2012.” *JAMA Pediatr.* 2015; 169 (7):673-677

<sup>3</sup> NAMI, <https://www.nami.org/Learn-More/Mental-Health-Conditions/Related-Conditions/Suicide>

<sup>4</sup> <http://www.nimh.nih.gov/health/statistics/prevalence/any-disorder-among-children.shtml>

<sup>5</sup> U.S. Department of Health and Human Services. Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, (1999). U.S. Public Health Service, Report of the Surgeon General’s Conference on Children’s Mental Health: A National Action Agenda. Washington, D.C., Department of Health and Human Services, (2000).

<sup>6</sup> Robert Wood Johnson Foundation, 2014. H. Wilder Foundation. Prepared by Cheryl Holm-Hansen. “Racial and Ethnic Disparities in Children’s Mental Health.” Saint Paul, Minnesota, October 2006, page 1: <http://www.wilder.org/Wilder-Research/Publications/Studies/Racial%20and%20Ethnic%20Disparities%20in%20Children's%20Mental%20Health/Racial%20and%20Ethnic%20Disparities%20in%20Children's%20Mental%20Health,%20Full%20Report.pdf>. See also: “Children’s Mental Health: Facts for Policymakers, National Center for Children in Poverty.” (November 2006)

<sup>7</sup> Amherst H. Wilder Foundation. Prepared by Cheryl Holm-Hansen. “Racial and Ethnic Disparities in Children’s Mental Health.” Saint Paul, Minnesota, October 2006, page 1: <http://www.wilder.org/Wilder-Research/Publications/Studies/Racial%20and%20Ethnic%20Disparities%20in%20Children's%20Mental%20Health/Racial%20and%20Ethnic%20Disparities%20in%20Children's%20Mental%20Health,%20Full%20Report.pdf>

<sup>8</sup> See: Kataoaka, S.H., Zhang, L., & Wells, K.B. (2002). “Unmet need for mental health care among U.S. children: Variation by ethnicity and insurance status.” *American Journal of Psychiatry*, 159(9), 1548-1555. ; Kodjo, C.M. & Auinger, P. (2004). “Predictors for emotionally distressed adolescents to receive mental health care.” *Journal of Adolescent Health*, 35(5), 368-373. ; Slade, E.P. (2004). “Racial/ethnic disparities in parent perception of child need for mental health care following school disciplinary events.” *Mental Health Services Research*, 6(2), 75-92. ; Yeh, M. et al. (2003). “Racial/ethnic differences in parental endorsement of barriers to mental health services for youth.” *Mental Health Services Research*, 5(2), 65-77.

<sup>9</sup> National Center for Mental Health and Juvenile Justice. “Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health

Needs in Contact with the Juvenile Justice System.” Prepared by Skowyra and Coccozza, 2007. Accessed online at [www.ncmhjj.com](http://www.ncmhjj.com)

<sup>10</sup> “Children’s Mental Health: Facts for Policymakers, National Center for Children in Poverty”, November 2006, [http://www.nccp.org/publications/pub\\_687.html](http://www.nccp.org/publications/pub_687.html)

<sup>11</sup> U.S. Department of Health and Human Services. “Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, (1999). U.S. Public Health Service, Report of the Surgeon General’s Conference on Children’s Mental Health: A National Action Agenda.” Washington, D.C., Department of Health and Human Services, (2000).

<sup>12</sup> NAMI, <https://www.nami.org/Learn-More/Mental-Health-Conditions/Related-Conditions/Suicide>

<sup>13</sup> <https://www.educateiowa.gov/sites/files/ed/documents/2013-12-16FinalReport-SuicidePrevention-TramaInformedCareTaskForce.pdf>

<sup>14</sup> According to the US Census Bureau in 2013 the population of Iowa was 3,090,416 and in 2011 23.6% of the Iowa Population was under 18 years of age.

(<http://www.iowadatacenter.org/quickfacts#section-6>) “Approximately 11-13 percent of children and youth have a serious emotional disturbance that causes substantial impairment in how they function at home, at school, or in the community, and for 5 percent a serious emotional disturbance causes extreme impairment in their functioning” (Surgeon General’s Conference on Children’s Mental Health; Merikangas, H, et al, 2010). Only 20% of American children and adolescents with mental illnesses are identified and receive services. (U.S. Public Health Service, Report of the Surgeon General’s Conference on Children’s Mental Health: A National Action Agenda. Washington, DC: Department of Health and Human Services, 2000.)

<sup>15</sup> “Twenty-third annual report to Congress on the implementation of the Individuals with Disabilities Education Act”, U.S. Department of Education, Washington, D.C., 2001, page xx-xxi: <https://www2.ed.gov/about/reports/annual/osep/2001/toc-execsum.pdf>

<sup>16</sup> National Center for Mental Health and Juvenile Justice. “Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System.” Prepared by Skowyra and Coccozza, 2007. Accessed online at [www.ncmhjj.com](http://www.ncmhjj.com)

<sup>17</sup> See page 40 of this document.

<sup>18</sup> “System of Care – A Sound Investment for our Youth”, ROI from Orchard Place.

<sup>19</sup> Division XXII, Section 102 of Senate File 505:

<http://coolice.legis.iowa.gov/Legislation/86thGA/enrolled/SF505.html>

<sup>20</sup> See <http://www.bazelon.org/Where-We-Stand/Community-Integration/Olmstead-Implementing-the-Integration-Mandate.aspx>

<sup>21</sup> Iowa Department of Human Services, “Iowa Mental Health and Disability Services Systems Redesign Final Report,” December 9, 2011, page 3

<sup>22</sup> *Iowa Mental Health and Disability Services System Redesign Interim Report to the Department of Human Services*, Prepared by the Technical Assistance Collaborative, Inc., October 31, 2011, page 17.

<sup>23</sup> The 2011-2012 Children’s disability Workgroup contained *only one parent representative* and the 2013 membership list *did not contain any*. (See

[https://dhs.iowa.gov/sites/default/files/rtFINAL\\_RedesignWrkgrpParticipants\\_pdfPages\\_11-29-2011\\_01-03-12rt.pdf](https://dhs.iowa.gov/sites/default/files/rtFINAL_RedesignWrkgrpParticipants_pdfPages_11-29-2011_01-03-12rt.pdf))

<sup>24</sup> Iowa Department of Human Services Children's Disability Services Workgroup, Final Report, November 15, 2013, page iii. <http://dhs.iowa.gov/sites/default/files/Childrens-Disability-Services-Workgroup-Final-Report-Nov-15-2013.pdf>

<sup>25</sup> Iowa Department of Human Services Workgroup Final Report, November 15, 2013, page 9. <http://dhs.iowa.gov/sites/default/files/Childrens-Disability-Services-Workgroup-Final-Report-Nov-15-2013.pdf>

<sup>26</sup> Iowa Department of Human Services Children's Disability Services Workgroup Final Report, November 15, 2013, page iii. <http://dhs.iowa.gov/sites/default/files/Childrens-Disability-Services-Workgroup-Final-Report-Nov-15-2013.pdf>

<sup>27</sup> 2011 Interim Report, pages 77-78.

<sup>28</sup> See for example Oregon: <http://www.oregon.gov/oha/amh/wraparound/docs/child-adolescent-mh-wraparound.pdf> ; Minnesota: <http://www.namihelps.org/2015-NAMI-Minnesota-Legislative-Summary.pdf> and <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-5051-ENG>; and [http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16\\_142333](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_142333); or Vermont: <http://mentalhealth.vermont.gov/services#cafu>;

<sup>29</sup> <http://www.ohchr.org/en/professionalinterest/pages/crc.aspx>

<sup>30</sup> <https://www.law.cornell.edu/supct/html/98-536.ZS.html>

<sup>31</sup> <http://idea.ed.gov/download/statute.html>

<sup>32</sup> Examples: trauma informed care, the sanctuary model, mind-body work, sensory integration, etc.

<sup>33</sup> National Council for Behavioral Health, 2014.

<sup>34</sup> National Center for Mental Health and Juvenile Justice. "Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System." Prepared by Skowyra and Coccozza, 2007. Accessed online at [www.ncmhjj.com](http://www.ncmhjj.com)

<sup>35</sup> Children's Mental Health: Facts for Policymakers, National Center for Children in Poverty, (November 2006).

<sup>36</sup> National Center for Mental Health and Juvenile Justice. "Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System." Prepared by Skowyra and Coccozza, 2007. Accessed online at [www.ncmhjj.com](http://www.ncmhjj.com)

<sup>37</sup> U.S. Department of Health and Human Services. Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, (1999). U.S. Public Health Service, Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda. Washington, D.C., Department of Health and Human Services, (2000).

<sup>38</sup> U.S. Department of Health and Human Services. Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, (1999). U.S. Public Health Service,

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Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda. Washington, D.C., Department of Health and Human Services, (2000).

<sup>39</sup> This passage is quoted directly from <http://www.bazelon.org/Where-We-Stand/Success-for-All-Children/Mental-Health-Services-for-Children/Wraparound-Services.aspx>

<sup>40</sup> The Regional Autism Assistance Program is currently developing a statewide strategic plan for autism spectrum disorders. It is based largely on previous efforts by the Iowa Autism Council, including this recent report with current priorities:

<https://www.legis.iowa.gov/docs/APPS/AR/1378A347-63D8-42BA-9C20-9CBE8D0018D5/Iowa%20Autism%20Leg%20Report.pdf>

<sup>41</sup> Using telemedicine to meet the needs of rural consumers and families continues to be a demand for both people with ASD and those with mental illness. The Iowa Autism Council (IAC) and the Iowa Psychiatric Society (IPS) communicated a plan to use telemedicine more extensively. IAC recommends using it to provide services to families who otherwise would experience hardship traveling to distant site with their children with disabilities.

<sup>42</sup> Minnesota, for example, has successfully implemented school linked mental health services:

[http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16\\_167208](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_167208)

<sup>43</sup> L., Breslau, J., Lane, M., Sampson, N. & Kessler, R.. Mental disorders and subsequent educational attainment in a US national sample.

<http://dx.doi.org/10.1016/j.psychires.2008.01.016>

<sup>44</sup> The National Survey on Drug Use and Health: The NSDUH Report, February 9, 2009, page 137.: [http://tapartnership.org/enterprise/docs/RESOURCE%20BANK/RB-MENTAL%20HEALTH/General%20Resources/Adolescent\\_MH\\_NSDUH\\_Youth\\_Survey\\_2009.pdf](http://tapartnership.org/enterprise/docs/RESOURCE%20BANK/RB-MENTAL%20HEALTH/General%20Resources/Adolescent_MH_NSDUH_Youth_Survey_2009.pdf)

<sup>45</sup> (Burns BJ, Costello EJ, Angold A, Tweed D et al. Children's Mental Health Service Use Across Service Sectors, *Health Affairs*, Vol. 14, No. 3, 1995: 149-159.

<sup>46</sup> Center for Health and Health Care in Schools at the Milken Institute School of Public Health at the George Washington University, "The Impact of School-Connected Behavioral and Emotional Health Interventions on Student Academic Performance: An Annotated Bibliography of research literature." (2014) <http://www.healthinschools.org/en/School-Based-Mental-Health/Revised-Annotated-Bibliography.aspx>

<sup>47</sup> Information in this table is taken verbatim from the Dignity in Schools Fact Sheet: Creating Positive School Discipline.

<sup>48</sup> Illinois Positive Behavior Interventions & Supports Network, 2006-07 Progress Report. <http://www.pbisillinois.org/>

<sup>49</sup> Illinois Positive Behavior Interventions & Supports Network, 2005-06 Progress Report. <http://www.pbisillinois.org/>

<sup>50</sup> Florida's Positive Behavior Support Project Annual Report 2007-2008. <http://flpbs.fmhi.usf.edu/index.asp>

<sup>51</sup> CADRE, Redefining Dignity in Our Schools: A Shadow Report on School-Wide Positive Behavior Support Implementation in South Los Angeles, 2010.

<sup>52</sup> Current SAMSHA grant funding through the Iowa Department of Education provides training on identifying and responding to mental health concerns, including suicide

ideation in youth (Youth Mental Health First Aid). However, this grant only provides training to three Iowa urban communities (Sioux City, Davenport, Waterloo) and six rural communities.

<sup>53</sup> <http://heartlandfamilyservice.org/what-we-do/programs-and-services/mental-health/#therapeutic-school>

<sup>54</sup> <https://www.educateiowa.gov/sites/files/ed/documents/2013-12-16FinalReport-SuicidePrevention-TramaInformedCareTaskForce.pdf>

<sup>55</sup> [http://www.ada.gov/olmstead/olmstead\\_about.htm](http://www.ada.gov/olmstead/olmstead_about.htm)

<sup>56</sup> <http://www.aecf.org/resources/every-kid-needs-a-family>

<sup>57</sup> <http://www.aecf.org/resources/every-kid-needs-a-family>

<sup>58</sup> <http://idea.ed.gov/explore/view/p/.root,regs,300,B,300%252E111>

<sup>59</sup> <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html>

<sup>60</sup> <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html>

<sup>61</sup> [https://dhs.iowa.gov/sites/default/files/9.4.15\\_Monthly\\_Slot\\_and\\_Waiting\\_list.pdf](https://dhs.iowa.gov/sites/default/files/9.4.15_Monthly_Slot_and_Waiting_list.pdf)

<sup>62</sup> <https://humanrights.iowa.gov/sites/default/files/media/JJDPAct.pdf>

<sup>63</sup> <https://humanrights.iowa.gov/sites/default/files/media/JJDPAct.pdf>

<sup>64</sup> See additional relevant action items in Section III below.

<sup>65</sup> <https://humanrights.iowa.gov/sites/default/files/media/JJDPAct.pdf>

<sup>66</sup> <https://humanrights.iowa.gov/sites/default/files/media/JJDPAct.pdf>

<sup>67</sup> <https://humanrights.iowa.gov/sites/default/files/media/JJDPAct.pdf>

<sup>68</sup> U.S. Department of Education Office for Civil Rights 1 Civil Rights Data Collection: Data Snapshot (School Discipline) March 21, 2014, page 1.

<sup>69</sup> This number is an aggregate based on two sources: Children's Defense Fund, May 2014. *Children in the States: Iowa* and U.S. Department of Education Office for Civil Rights 1 Civil Rights Data Collection: Data Snapshot (School Discipline) March 21, 2014, page 1.

<sup>70</sup> These figures are an aggregation from multiple sources. This is our best estimate with the data that is available. Iowa spends on average \$298.50 / day for the juvenile detention of children with mental illness. (["Iowa Kids: After a crime, a second chance: Iowa keeps most kids out of court; activists say that's still not enough."](#) Sharyn Jackson, *The Des Moines Register*, Nov. 2, 2013.) The daily average population in Juvenile Detention in Iowa is \$124.04. (["Serving Iowa Youth and Families with a Positive Youth Development Approach: JJDP Act Formula Grant Application and Three-Year Comprehensive Plan"](#), Iowa Department of Human Rights, Division of Criminal and Juvenile Justice Planning and Iowa's Juvenile Justice Advisory Council, June 2012, page 57.) 70% of children in juvenile detention have mental illness (["Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System."](#) National Center for Mental Health and Juvenile Justice, Skowrya and Coccozza, 2007) That comes to 86.828 children with mental illness / year that that Iowa incarcerates. 86.828 children \* \$298.50 / day for juvenile detention \* 365 days/year = \$9,460,127.67 / year Iowa is paying to incarcerate youth with mental illness. On the other hand, providing one child wraparound services for a year costs \$2637.50. (This number is based on the Return on Investment prepared by Orchard Place called "System of Care – A Sound Investment in our Youth", which says the cost of 1 year of wraparound



services for 80 children cost \$211,000.) \$2637.50 / year for wraparound care for the same 86.828 children with mental illness that Iowa incarcerates would cost \$229,008.05. Iowa spends approximately \$9,460,127.67 / year to incarcerate youth with mental illness. The state would save \$9,231,118.82 / year if it chose instead to provide these children with wraparound mental health services, which would cost only \$229,008.05 / year. (That is a savings of \$40.31 on the dollar.)

<sup>71</sup> Centers for Disease Control and Prevention,

<http://www.cdc.gov/ncbddd/disabilityandsafety/wandering.html#ref>, accessed July 7, 2015.

<sup>72</sup> McIlwain, Lori and Wendy Fournier. "Lethal Outcomes in Autism Spectrum Disorders (ASD) Wandering / Elopement." National Autism Association, January 20, 2012, page 4.

<sup>73</sup> McIlwain, Lori and Wendy Fournier. "Lethal Outcomes in Autism Spectrum Disorders (ASD) Wandering / Elopement." National Autism Association, January 20, 2012, page 4.

<sup>74</sup> AWAARE (Autism Wandering Awareness Alerts Response and Education)

<http://awaare.nationalautismassociation.org/>, accessed July 7, 2015.

<sup>75</sup> McIlwain, Lori and Wendy Fournier. "Lethal Outcomes in Autism Spectrum Disorders (ASD) Wandering / Elopement." National Autism Association, January 20, 2012, page 4.

<sup>76</sup> McIlwain, Lori and Wendy Fournier. "Lethal Outcomes in Autism Spectrum Disorders (ASD) Wandering / Elopement." National Autism Association, January 20, 2012, page 4.

<sup>77</sup> McIlwain, Lori and Wendy Fournier. "Lethal Outcomes in Autism Spectrum Disorders (ASD) Wandering / Elopement." National Autism Association, January 20, 2012, pages 4 and 6.

<sup>78</sup> [www.smart911.com](http://www.smart911.com)

<sup>79</sup> Other states (e.g., Michigan and Arkansas) have statewide services.

<sup>80</sup> Juvenile Law Center, Failed Policies, Forfeited Futures: A Nationwide Scorecard on Juvenile Records.

[www.modelsforchange.net/publications/651/Failed\\_Policies\\_Forfeited\\_Futures\\_A\\_Nationwide\\_Scorecard\\_on\\_Juvenile\\_Records.pdf](http://www.modelsforchange.net/publications/651/Failed_Policies_Forfeited_Futures_A_Nationwide_Scorecard_on_Juvenile_Records.pdf) Accessed 5-28-15

<sup>81</sup> NCIE (National Center on Inclusive Education) At the Institute on Disability, University of New Hampshire. "Who Cares about Kelsey? Key Statistics." Page 1.

<sup>82</sup> Baglivio, Michael T., Nathan Epps, Kimberly Swartz, Mona Sayedul Huq, Amy Sheer and Nancy S. Hardt. (2014) "The Prevalence of Adverse Childhood Experiences (ACE) in the Lives of Juvenile Offenders." *OJJDP: Journal of Juvenile Justice*, Vol. 3, #2, page 9.

<sup>83</sup> New York City's Comptroller's Office, "The Suspension Spike: Changing the Discipline Culture in NYC's Middle Schools" July 2003, page 18.

<sup>84</sup> Balfanz, Robert Herzog, Liza, and Mac Iver, Douglas J., "Preventing Student Disengagement and Keeping Students on the Graduation Path in Urban Middle-Grades Schools. Early Identification and Effective Interventions." *Educational Psychologist*, 42 (4) 2007, cited in New York City's Comptroller's Office, "The Suspension Spike: Changing the Discipline Culture in NYC's Middle Schools" July 2003, page 21.

<sup>85</sup> New York City's Comptroller's Office, "The Suspension Spike: Changing the Discipline Culture in NYC's Middle Schools" July 2003, page 23.

<sup>86</sup> U.S. Department of Education Office for Civil Rights, *Civil Rights Data Collection: Data Snapshot: School Discipline*, Issue Brief No. 1 (March 2014), page 18.

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- <sup>87</sup> U.S. Department of Education Office for Civil Rights, *Civil Rights Data Collection: Data Snapshot: School Discipline*, Issue Brief No. 1 (March 2014), page 16.
- <sup>88</sup> Children's Defense Fund, May 2014. *Children in the States: Iowa*.
- <sup>89</sup> U.S. Department of Education, Twenty-third annual report to congress on the implementation of the Individuals with Disabilities Education Act, Washington , D.C., 2001. (noted in NAMI Feb. 2009 page 8)
- <sup>90</sup> Wagner, M. (1995). Outcomes for youths with serious emotional disturbance in secondary school and early adulthood. *The Future of Children: Critical Issues for Children and Youths*, 5(4), 90-112. (Noted in NAMI Feb, 2009)
- <sup>91</sup> Rush, S. *Improving Education for Students with Emotional Disturbance*. Knowability. Retrieved February 3, 2009, from [www.knowability.org/research/?content=improve](http://www.knowability.org/research/?content=improve). (Noted in NAMI Feb, 2009 page 8)
- <sup>92</sup> U.S. Department of Education Office for Civil Rights, *Civil Rights Data Collection: Data Snapshot: School Discipline*, Issue Brief No. 1 (March 2014), page 12.
- <sup>93</sup> U.S. Department of Education Office for Civil Rights, *Civil Rights Data Collection: Data Snapshot: School Discipline*, Issue Brief No. 1 (March 2014), page 14.
- <sup>94</sup> Children's Defense Fund, May 2014. *Children in the States: Iowa*.
- <sup>95</sup> "Are our Children Being Pushed into Prison?" from suspensionstories.com
- <sup>96</sup> Children's Defense Fund, May 2014. *Children in the States: Iowa*.
- <sup>97</sup> <http://samhsa.gov/children/data.asp>
- <sup>98</sup> Powerpoint, UWMilwaukee, Helen Bader school of Social Welfare, slide 15 (file ACE crime.PDF)
- <sup>99</sup> Baglivio, Michael T., Nathan Epps, Kimberly Swartz, Mona Sayedul Huq, Amy Sheer and Nancy S. Hardt. (2014) "The Prevalence of Adverse Childhood Experiences (ACE) in the Lives of Juvenile Offenders." *OJJDP: Journal of Juvenile Justice*, Vol. 3, #2, page 9.
- <sup>100</sup> Reavis James A, Jan Looman, Kristina A Franco, Briana Rojas. (Spring 2013). "Adverse Childhood Experiences and Adult Criminality: How Long Must We Live before We Possess Our Own LPowerives?" *The Permanente Journal* Vol 17, #2, page 46. <http://dx.doi.org/10.7812/TPP/12-072>
- <sup>101</sup> *Executive Summary: Safe, Healthy, and Ready to Learn: Policy Recommendations to Ensure Children Thrive in Supportive Communities Free from Violence and Trauma*, May 2015.
- <sup>102</sup> "Are our Children Being Pushed into Prison?" from <http://www.suspensionstories.com>
- <sup>103</sup> "Are our Children Being Pushed into Prison?" from <http://www.suspensionstories.com>
- <sup>104</sup> "Are our Children Being Pushed into Prison?" from <http://www.suspensionstories.com>
- <sup>105</sup> "Are our Children Being Pushed into Prison?" from <http://www.suspensionstories.com>
- <sup>106</sup> <http://www.aecf.org/resources/every-kid-needs-a-family>
- <sup>107</sup> <http://www.aecf.org/resources/every-kid-needs-a-family>
- <sup>108</sup> <http://www.aecf.org/resources/every-kid-needs-a-family>
- <sup>109</sup> *Safe, Healthy, and Ready to Learn: Policy Recommendations to Ensure Children Thrive in Supportive Communities Free from Violence and Trauma*, May 2015. [http://d3vc4vygg8dc62.cloudfront.net/wp-content/uploads/Safe-Healthy-and-Ready-to-Learn\\_Executive-Summary.pdf](http://d3vc4vygg8dc62.cloudfront.net/wp-content/uploads/Safe-Healthy-and-Ready-to-Learn_Executive-Summary.pdf)
- <sup>110</sup> New York City's Comptroller's Office, "The Suspension Spike: Changing the Discipline Culture in NYC's Middle Schools" July 2003, page 31.



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- <sup>111</sup> Costello, Bob et al., “Restorative Practices Handbook” page 7.
- <sup>112</sup> Costello, Bob et al., “Restorative Practices Handbook” page 68. Whole quote from
- <sup>113</sup> New York City’s Comptroller’s Office, “The Suspension Spike: Changing the Discipline Culture in NYC’s Middle Schools” July 2003, page 30.
- <sup>114</sup> Russell Skiba et al., “Are Zero Tolerance Policies Effective in the Schools?,” American Psychological Association Zero Tolerance Task Force, 2006. (The following data are taken verbatim from the “Dignity in Schools Fact Sheet: Creating Positive School Discipline” page 1.)
- <sup>115</sup> Advancement Project, Stop the Schoolhouse to Jailhouse Track.  
<http://www.stopschoolstojails.org/padres-jovenes-unidos-denver.html>
- <sup>116</sup> Caralee Adams, “The Talk It Out Solution: How can you promote safety? Try getting rid of the metal detectors,” Scholastic Administrator, November/December 2008. See video: “The Transformation of West Philadelphia High School: A Story of Hope”  
<http://www.iirp.org/westphilahigh/>
- <sup>117</sup> Sharon Lewis, Ed., “Improving School Climate: Findings from Schools Implementing Restorative Practices,” International Institute for Restorative Practices, May 19, 2009.  
<http://www.iirp.org/pdf/IIRP-Improving-School-Climate.pdf>
- <sup>118</sup> Bradley Olson and Judah Viola, “Chicago Public Schools High School Peer Jury Program Evaluation Report,” DePaul University, September 2007.
- <sup>119</sup> Chloe Wiley, “Peer juries reduce suspensions, increase attendance at Chicago public schools,” Windy Citizen, May 23, 2008.
- <sup>120</sup> U.S. Department of Education Office for Civil Rights 1 Civil Rights Data Collection: Data Snapshot (School Discipline) March 21, 2014, page 9.
- <sup>121</sup> U.S. Department of Education Office for Civil Rights 1 Civil Rights Data Collection: Data Snapshot (School Discipline) March 21, 2014, page 18.
- <sup>122</sup> U.S. Department of Education Office for Civil Rights 1 Civil Rights Data Collection: Data Snapshot (School Discipline) March 21, 2014, page 10.
- <sup>123</sup> U.S. Department of Education Office for Civil Rights 1 Civil Rights Data Collection: Data Snapshot (School Discipline) March 21, 2014, page 9.
- <sup>124</sup> U.S. Department of Education Office for Civil Rights 1 Civil Rights Data Collection: Data Snapshot (School Discipline) March 21, 2014, page 9.
- <sup>125</sup> U.S. Department of Education Office for Civil Rights 1 Civil Rights Data Collection: Data Snapshot (School Discipline) March 21, 2014, pages 1, 12, and 14.
- <sup>126</sup> “Note: Detail may not sum to 100% due to rounding. Figure reflects 99% of schools offering preschool, including over 1 million preschool students, nearly 5,000 students suspended once, and over 2,500 students suspended more than once. Preschool suspensions and expulsions were collected for the first time in 2011–12.” U.S. Department of Education Office for Civil Rights 1 Civil Rights Data Collection: Data Snapshot (School Discipline) March 21, 2014, page 7.
- <sup>127</sup> See Safe, Healthy, and Ready to Learn: Policy Recommendations to Ensure Children Thrive in Supportive Communities Free from Violence and Trauma, May 2015.  
[http://d3vc4vygg8dc62.cloudfront.net/wp-content/uploads/Safe-Healthy-and-Ready-to-Learn\\_Executive-Summary.pdf](http://d3vc4vygg8dc62.cloudfront.net/wp-content/uploads/Safe-Healthy-and-Ready-to-Learn_Executive-Summary.pdf)
- <sup>128</sup> Christopher Blodget, “No School Alone: How Community Risks and Assets Contribute to School and Youth Success.” Report prepared for the Washington State Office of Financial

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Management in response to the Legislature's directions in Substitute House Bill 2739, pages 57-59.

<sup>129</sup> U.S. Department of Education Office for Civil Rights 1 Civil Rights Data Collection: Data Snapshot (School Discipline) March 21, 2014, page 1.

<sup>130</sup> See NAMI 2001 *Responding to youth with Mental Health Needs: A CIT for Youth Implementation Manual*. To access this publication, visit [www.nami.org/citforyouth](http://www.nami.org/citforyouth). To purchase a hard copy of this publication, visit [www.nami.org/store.c](http://www.nami.org/store.c)

<sup>131</sup> <http://www.aceinterface.com>